STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	155001	A. Building B. Wing	12/30/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Hooverwood	7001 Hoover Rd Indianapolis, IN 46260

For information on the nursing home's plan to correct this deficiency, please contact the nursing home or the state survey agency.

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0689 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	Ensure that a nursing home area is free from accident hazards and provides adequate supervision to prevent accidents. Based on observation, interview and record review, the facility failed to ensure a resident with a diagnosis of dementia who resided on a secured locked unit and at risk of elopement did not exit the facility unsupervised for 1 of 3 residents reviewed for accidents. (Resident B) Resident B wandered approximately 0.4 miles away from the facility and had crossed a two-lane road.The immediate jeopardy began, on 12/23/25, when Resident B exited the facility unsupervised and without the staff's knowledge while wearing a wanderguard device (a wearable device used to alert staff when a resident approached restrictive areas/doors). The resident exited the secured locked unit through an unlocked stairway door, went down the stairwell to the first floor, and exited the facility through an unlocked but alarmed door. Facility staff reset the door alarm without being able to determine the cause of the alarm. Resident B was found walking down the road in the grass by Certified Nursing Assistant (CNA) 2. The Director of Nursing (DON) was notified of the immediate jeopardy on 12/29/25 at 2:27p.m. Findings include:During an interview, on 12/29/25 at 9:22 a.m., the DON indicated the stairway door on the secured locked unit was supposed to be locked. It required a key to engage the door lock. The door should be checked every morning by the Maintenance Director to ensure it was locked, and it was not checked the morning of the incident. Resident B had ambulated with her walker into the stairwell, left her walker in the stairwell, and walked down the stairs. The resident then exited the stairwell into the first-floor hallway and out an exit door. The exit door did sound an alarm however the door was not locked and it should have been. After the incident, the facility had a company check the function of all the doors and found the door Resident B went out had been tampered with which caused the door to not lock when it was closed. A plastic white wristband had been folded up and placed in a location which altered the door and resulted in the door not working properly.During an observation and interview, on 12/29/25 at 12:20 p.m., the DON played a video of the facility camera footage from the day of the incident. The video started at 1:18 p.m., on 12/23/25. The camera faced down the hallway. Resident B could be seen walking down the hallway away from the camera and towards the stairwell around 1:20 p.m. At 1:24 p.m., she was observed on another camera exiting the stairwell into the first-floor hallway and exiting the building to the parking lot. At 1:26 p.m., LPN 7 and LPN 8 responded to the alarm sounding from the door Resident B had used to exit to the parking lot and at 1:27 p.m., turned off the alarm. The two staff members were observed to look out the window. They were not observed to open the door or step outside to look around. At 1:33 p.m., the staff on the resident's secured locked unit were observed to begin searching for the resident. The recorded footage clip ended around 1:33 p.m. The DON indicated she was not aware the staff members had reset the door alarm and did not open the door or step outside to assess the surrounding area.A typed facility document, dated 12/23/25, indicated at 1:41 p.m., a missing resident code was called. At 1:48 p.m., the police were notified of a missing resident. At 1:52 p.m., the facility staff found Resident B. Resident B was assessed and found to be without injury.The clinical record for (continued on next page)

Any deficiency statement ending with an asterisk (*) denotes a deficiency which the institution may be excused from correcting providing it is determined that other safeguards provide sufficient protection to the patients. (See instructions.) Except for nursing homes, the findings stated above are disclosable 90 days following the date of survey whether or not a plan of correction is provided. For nursing homes, the above findings and plans of correction are disclosable 14 days following the date these documents are made available to the facility. If deficiencies are cited, an approved plan of correction is requisite to continued program participation.

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE	TITLE	(X6) DATE

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F 0689 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	Resident B was reviewed on 12/29/25 at 10:22 a.m. The diagnoses included, but were not limited to, dementia, hypertension, congestive heart failure, depression, and glaucoma.A physician's order, dated 6/23/24, indicated Resident B had a wanderguard device.An elopement assessment, dated 10/14/25, indicated Resident B was at risk for elopement.A quarterly Minimum Data Set (MDS) assessment, dated 12/12/25 at 4:40 p.m., indicated Resident B was severely cognitively impaired, had wandering behaviors, and wandering and elopement alarms were utilized daily.A care plan, dated 6/25/24, indicated Resident B was at risk for elopement. The interventions included, but were not limited to, distracting the resident from wandering or exit seeking by offering pleasant diversions, calling daughter on the phone or have daughter come in person to the facility, redirect attention, and place a wanderguard on the right wrist.A behavior note, dated 11/6/25 at 12:35 p.m., indicated Resident B was noted to be going out the west end door, staff were able to catch up with Resident B as she reached the curve of the sidewalk. Staff tried to convince Resident B to come back inside, however she refused. Resident B started toward the front entrance, a nurse and CNA were walking with her, when Resident B almost fell trying to get back up on the sidewalk. The nurse was able to catch her. Staff continued to try to get her into the building and tried calling her daughter. The Social worker came and sat with Resident B for a while and then brought her back to the unit. The Social worker called Resident B's daughter and was able to get the resident moved up to the secured unit. Resident B was administered an as needed Ativan (antianxiety medication) before she went upstairs because she was really agitated.A social service note, dated 11/6/25 at 1:15 a.m., indicated 1:1 was provided to Resident B outside as she was not ready to come inside. After 5 minutes, Resident B indicated she was ready to come in as it was getting cool outside. During the visit, Resident B's daughter was called regarding moving Resident B to a closed unit. The last updated care plan intervention for the care plan, dated 6/25/24, which indicated Resident B was at risk for elopement was 10/7/25. There were no updated interventions documented after Resident B had exited the facility on 11/6/25 and was moved to a locked secured unit.A social service note, dated 12/18/25 at 1:33 p.m., indicated the psychiatric physician, Nurse Practitioner, and Resident B's daughter were aware of the resident's ongoing wandering into other rooms, exit seeking, walking without her rollator walker, and becoming aggressive when staff attempted to redirect her. Labs were ordered and the resident refused. The staff would continue to gently redirect her when she wandered and was exit seeking and would call her daughter to speak with her. A physician's note, dated 12/18/25 at 2:54 p.m., indicated Resident B was seen for a follow-up on increased confusion and had wandered into other residents' rooms earlier this week. A behavior note, dated 12/21/25 at 2:34 p.m., indicated Resident B wandered into other residents' rooms repeatedly, was redirected several times, and stated to the CNA, It's sunny out and I want to go see outside.An incident note, dated 12/23/25 at 2:15 p.m., indicated the nurse was alerted by a CNA Resident B could not be found. A search of the unit began. Resident B had a history of wandering. The nurse also looked off unit to see if she was at an activity or in therapy. When Resident B could not be found, the receptionist was told to call a code purple. As the search continued, the stairwell entry was opened with no alarm sounding and the resident's walker was in the stairwell. Staff members went down the stairway. Once staff were down onto the first floor, no alarms were heard sounding. Staff pushed the exit door to see if the alarm would sound and it did. The search continued. Once Resident B was found, a skin assessment and vital signs were completed. Resident B did have a smear of mud on the back of her pants. The resident stated, the grass was slippery, I kept sliding. Resident B had no bruises, scratches, or open areas on her body.During an interview, on 12/29/25 at 10:51 a.m., CNA 2 indicated she found Resident B walking down the road. She was down the road, across the street from the (continued on next page)

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F 0689 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	facility, and walking in the grass. The side of the road the resident was walking down did not have a sidewalk. During an interview, on 12/29/25 at 2:41 p.m., the DON indicated the facility elopement policy did not include how staff were to respond when a door alarm was activated. During an interview, on 12/29/25 at 2:58 p.m., Resident B's daughter indicated, on 12/23/25 around 2:30 p.m., she was notified her mom had gotten out of the building and was located down the road. The resident had also gotten out in November when she resided on the first floor, so she was moved upstairs to the locked unit for safety. Whenever her mom was having exit seeking episodes, the facility would call her so she could talk to Resident B and help calm her down. When she exited in November, the facility called her and she was able to talk Resident B to returning inside the facility. Resident B had now been moved to another locked unit in the facility. During an interview, on 12/29/25 at 3:14 p.m., LPN 7 indicated, on 12/23/25 sometime after lunch, she was by the nurse's station when she heard an alarm going off. She was unsure what the alarm was. Her and another nurse followed the sound to the west door at the end of the hallway. They looked out the door through the window and didn't see anyone. She then reset the alarm. They counted the residents on their unit (which was on the first floor), and they were all accounted for. She did not know about the elopement until later when the facility called a code purple.A facility document from an electronics company, dated 12/24/25, indicated the company was asked to test all door locking systems that exit the property. Each door locking system was checked and all systems were working properly.A current facility policy, titled Elopement Prevention and Response Program, dated 1/22 and provided from the Director of Nursing on 12/29/25 at 9:45 a.m., indicated .provide a safe and secure environment for the residents and in the event of a missing resident, ensuring appropriate action is taken.This citation relates to Intake 2700433.3.1-45(a)(1)3.1-45(a)(2)