STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	155156	A. Building B. Wing	04/01/2026

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Aperion Care Arbors Michigan City	1101 E Coolspring Ave Michigan City, IN 46360

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. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on record review and interview, the facility failed to initiate effective resident-specific interventions and provide adequate supervision to prevent the elopement from the facility of a resident with a diagnosis of dementia, a history of exit-seeking behaviors and a wanderguard (door alarm bracelet) in place for 1 of 3 residents reviewed for elopement risk. The resident exited the building without the knowledge of the staff working in the facility and was found the next day by the local police department and was taken to the hospital Emergency Room. (Resident B)The Immediate Jeopardy began on [DATE], when the facility was unaware that the resident had exited the facility without supervision. The resident walked independently and was found over 24 hours later by local police, and Emergency Services transported the resident to the hospital. The Administrator, Director of Nursing (DON), and [NAME] President of Clinical Operations were notified of the immediate jeopardy on [DATE] at 3:55 p.m. The immediate jeopardy was removed and the deficient practice corrected on [DATE], prior to the start of the survey, and was therefore past noncompliance. Finding includes:The record for Resident B was reviewed on [DATE] at 10:11 a.m. Diagnoses included, but were not limited to, dementia, anxiety, unspecified psychosis, adult failure to thrive, personal history of traumatic brain injury, bipolar disorder, cognitive communication deficit, difficulty walking, and depression. The Quarterly Minimum Data Set (MDS) assessment, dated [DATE], indicated the resident had severe cognitive impairment for daily decision making. The resident required supervision for all activities of daily living (ADLs) and transfers. An Elopement Risk and Community Survival Skills assessment, dated [DATE], indicated the resident should be placed on elopement risk protocol.A Care Plan, dated [DATE], indicated the resident required supervision when out in the community. An approach was for a survival skills assessment to be conducted quarterly to determine safety when outside in the community.A Care Plan, dated [DATE], indicated the resident resided on a secured unit related to dementia diagnosis. Approaches were to validate the resident's fears and concerns through listening and explain all care and reasons before beginning.A Care Plan, dated [DATE], indicated the resident had a history of exit-seeking and wandering and was at risk for elopement. Approaches were to anticipate care needs and provide them before the resident became overly stressed, administer medications and observe for side effects and attempt to redirect.An Elopement Risk and Community Survival Skills assessment, dated [DATE], indicated the resident should be placed on elopement risk protocol.A Social Service Note, dated [DATE] at 2:26 p.m., indicated a message was left with the resident's daughter related to a decision to transition the resident off memory care to a regular Long-Term care bed per her request. The interdisciplinary team agreed and the transfer was scheduled for [DATE] to room [ROOM NUMBER]. A Wanderguard would be placed during transition for safety.A Nurse's Note, dated [DATE] at 1:16 p.m., indicated the resident had transitioned from memory care unit to a less restrictive unit within the facility. The daughter was present at time of transfer, and the resident tolerated the move without distress. Upon arrival to the new unit, the resident had adjusted appropriately to his new environment. No concerns were noted and would continue to monitor for ongoing adjustment and safety.A Social Service's Note, dated [DATE] at 9:09 a.m., indicated a wanderguard was placed on (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	the resident's left ankle.A Nurse's Note, dated [DATE] at 9:00 p.m., indicated the resident was outside of the facility and a code pink was announced. Nurses and aides looked in rooms and outside the building.An Indiana Department of Health (IDOH) facility reported incident, dated [DATE], indicated Resident B had left the facility without notifying staff. The Administrator and Director of Nursing (DON) went to the facility and initiated the investigation. The local police department was notified and assisted with search of the resident. The next day on [DATE] at 1:50 p.m., the resident was found by police and was transported to the hospital for evaluation. No injury was reported.The facility's investigation follow up indicated all staff had been educated on elopement and wander guards, an audit was completed on wander guard residents by the Director of Nursing over 72 hours, the wanderguard system was inspected and found to be in correct working order, written statements by all staff who worked on [DATE], a timeline of events, and an abatement plan were included in the investigation binder.A written statement on [DATE] by Activity aide 1 indicated she had let Resident B out for a 1:00 p.m. smoke break. The resident had not seemed annoyed or on edge and he enjoyed the weather. He had gone back inside the building shortly after his smoke break.A written statement on [DATE] by QMA 1 indicated her statement served as a search and rescue /recovery effort that was initiated at 7:50 p.m. on [DATE] and ongoing. From 7:50 p.m.-11:30 p.m., she had coordinated an intensive search with another CNA. They performed multiple sweeps of the facility's interior, courtyard, and exterior perimeter. They drove through Michigan City for three hours or longer checking local landmarks, intersections, and areas the resident was known to frequent. All staff and management were looking for the resident. Law enforcement was notified, and the nurse contacted the Power of Attorney (POA).A written statement from CNA 1 on [DATE] indicated she had not seen the resident from room [ROOM NUMBER] (Resident B) at all on her 2:00p.m. to 10:00 p.m. shift.A written statement by LPN 2 on [DATE] indicated he was at the nurse's station when an aide came up to him and said she thought she had seen a resident outside. I went to look and did not see a resident and came back in and informed the DON. I then made an announcement to look for the resident.A written statement by Social Services on [DATE] indicated she placed a brand new wanderguard to the resident's left ankle, it was not expired, it was brand new from the package.A written statement by CNA 2 on [DATE] indicated at 9:10 p.m. on [DATE] a code pink was called. She had seen QMA 1 coming down the hall and she had said she was going to drive around and look for the resident. CNA 2 offered to go with her and drive. They looked around the whole building and the building next door, then they drove around to stores, gas stations, and parks.A Police Report, obtained on [DATE] at 1:33 p.m., indicated a police officer was dispatched to the facility on [DATE] at 10:01 p.m. because a resident had left the facility unattended. The executive director explained that the resident had been at the facility since [DATE] and had dementia. Staff were able to get in contact with the resident's daughter via telephone and she had reached out to the resident's friends who lived in the area. One of the residents' friends indicated Resident B had come to her house on a nearby street at approximately 1:30 p.m. and left at approximately 5:30 p.m. She had given the resident $20.00, and the resident indicated he was going to get a hot dog. On Thursday [DATE] at 9:40 a.m., a K9 officer responded to an attempt to locate the resident. A scent article was obtained from the resident's belongings to assist in the K9 search. Due to resident B's condition and an approaching storm reported for the area, assistance was requested from a nearby county Search and Rescue. The local County deputies and another nearby city police force deployed [NAME] to search for Resident B. At approximately 1:47 p.m., Resident B was seen walking out from a nearby wooded/dead end area. The resident was in the same clothing he was reported missing in and was stumbling, covered in dirt/moss and disoriented. He was unable to identify where he was from. He made statements that indicated confusion including that he had no blood left in his heart and could not eat. The resident refused medical treatment and indicated he would not go back to the facility. The resident's daughter/ power of attorney (POA) requested the resident be transported to the hospital for evaluation. The resident was placed under emergency detention for evaluation.A Physician's Order, dated [DATE] at 3:00 p.m., indicated to (continued on next page)

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F 0689 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	observe wanderguard on left ankle for placement every shift.A Nurse's Note, dated [DATE] at 1:49 p.m., indicated Resident B was located by police officers and taken to the hospital for evaluation.The Medication Administration Record for [DATE] indicated the wanderguard was signed out on [DATE] for the evening shift. There was no written plan for the safe adjustment of Resident B from the locked memory care unit to an unsecured unit. The record lacked 15-minute safety checks and there was no 72-hour charting or assessments initiated to document safety and adjustment.The resident's care plan related to exit-seeking and wandering had not been updated to reflect new interventions or the room change off of the locked memory care unit.During an interview on [DATE] at 10:57 a.m., the Administrator indicated Resident B was originally admitted to the 400 unit for rehab in December. Staff had noticed the resident was wandering in the hallways and exit-seeking, so they made the decision to move him to the secure memory care unit in January. He was on the secured unit with no exit-seeking behaviors and had a good mentation. The POA/resident's daughter works in health care and indicated her dad had rights and the facility was stifling his psychosocial development by keeping him on the secured unit. They had noticed no exit-seeking behaviors for the last 3 months, so they graduated him out of the secured unit. The resident moved out of the secured unit on [DATE].During an interview on [DATE] at 11:11 a.m., the DON indicated the wanderguard alarms did not go off because the resident had removed the wanderguard prior to exiting the facility. They had been searching for the wanderguard but had not located it. She had the alarm system tested and everything was working properly.During an interview on [DATE] at 1:18 p.m., CNA 1 indicated she had been working as an aide on the 200 unit, but Resident B was not in her line up. She had seen the resident around lunchtime as he was walking toward the dining room. She had not noticed any exit-seeking behavior at the time. She did not check for a wanderguard because she did not know he had one until after the fact. She found out the next day after he had already left the building.During an interview on [DATE] at 1:28 p.m., CNA 2 indicated she was working as an aide on the 200 unit. She indicated that Resident B was in her line up, but she had not received shift report and did not know there was a new resident in room [ROOM NUMBER]. She had not seen Resident B at all her entire shift, she did not even know what he looked like. Resident B's roommate stays out of his room all day until it is time for bed and he does not like going back to his room. The first time she stepped into room [ROOM NUMBER] was about 8:30 p.m. when she was putting Resident B's roommate to bed. That was when she realized there was an unmade bed and a cell phone. She asked LPN 1 about the resident's wherabouts and he told her the resident had a wanderguard on. They then began searching for the resident throughout the building. She had to look up the resident's picture because she had no idea what he looked like.QMA 1 and LPN 2 were unavailable for interview during the survey.On [DATE] at 3:44 p.m., video surveillance was reviewed with the Administrator. Resident B was seen returning to the facility in a silver car and exited the passenger's side of the car at 11:20 a.m. The resident remained in the front of building and then at approximately 11:24 a.m., the resident was seen walking away from the building toward the street wearing the same clothing that matched the description given to police.During an interview at the time, the Administrator indicated there was no video surveillance of the resident returning inside the facility or initially leaving. He also pointed out that there was no wanderguard on the resident's left leg and noted it would be bulky around the ankle since the tag sticks out. He indicated that was how it had normally looked on the resident. The police were given the details on the silver car and had no update on who the car belonged to. The administrator was unsure if the resident exited initially from the front door or a different door, but another resident could have given him the passcode. All doors are locked and require a passcode for entry and exit.During an interview on [DATE] at 3:55 p.m., the Administrator and Regional Nurse Consultant indicated they understood the immediate jeopardy concerns and said there should have been more safety checks initiated for Resident B after being moved off of the locked memory care unit.On [DATE] at 10:00 a.m., the Wanderguard alarm system at the front door was checked with the Maintenance Director, DON, Administrator and Resident E (wanderguard resident) and the alarm (continued on next page)

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