

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 155042	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 04/19/2024
NAME OF PROVIDER OR SUPPLIER Aperion Care Vincennes		STREET ADDRESS, CITY, STATE, ZIP CODE 3801 Old Bruceville Road, Box 136 Vincennes, IN 47591	

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)
<p>F 0554</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Allow residents to self-administer drugs if determined clinically appropriate.</p> <p>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 39130</p> <p>Based on observation, interview, and record review, the facility failed to ensure that a resident was clinically appropriate to administer their own medications without supervision by qualified staff during a random observation during the survey. A resident was alone in their room with a cup of medications sitting at their bedside table. (Resident F)</p> <p>Finding includes:</p> <p>During an observation and interview on 4/19/24 at 11:40 A.M., Resident F was sitting up in their bed at a bedside table. A medication cup holding six medication tablets and/or capsules had been placed on the bedside table. Resident F indicated not knowing what the medications were and that she intended to take the medications after lunch.</p> <p>During record review on 4/19/24 at 12:15 P.M., Resident F's diagnoses included, but were not limited to heart failure and anxiety.</p> <p>Resident F's most recent Quarterly MDS (Minimum Data Set) assessment dated [DATE] included that the resident had no cognitive impairment.</p> <p>Resident F's physician orders included, but were not limited to, Cardizem 180 mg (milligrams) 1 capsule, lisinopril 5 mg 1 tablet, ferrous sulfate 325 mg 1 tablet, tramadol 50 mg 1 tablet, potassium chloride 1 tablet, and furosemide 40 mg 1 tablet, all ordered to be administered at noon.</p> <p>No physician order to self administer medication was in the record.</p> <p>No medication self-administration assessments were found in Resident F's record.</p> <p>During an interview on 4/19/24 at 2:40 P.M., LPN 5 indicated that Resident F should be supervised when taking her medications.</p> <p>On 4/19/24 at 2:45 P.M., the DON (Director of Nursing) indicated that resident's who do not administer their own medications should be observed during medication administration and that nursing staff should not leave a resident with their medications.</p> <p>On 4/19/24 at 3:15 the Facility Administrator supplied a list of residents who self-administered their medications. Resident F was not on the medication self-administration list.</p> <p>(continued on next page)</p>

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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<p>F 0554</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>ON 4/19/24 at at 3:20 P.M., the Facility Administrator supplied a facility policy titled Self-Administration of Medication, dated 04/2014. The policy included, .1. A resident may not be permitted to administer or retain any medication in his/her room unless so ordered, in writing, by the attending physician .</p> <p>This citation relates to complaint IN00431340.</p> <p>3.1-11(a)</p>		

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<p>F 0656</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Develop and implement a complete care plan that meets all the resident's needs, with timetables and actions that can be measured.</p> <p>39130</p> <p>Based on observation, interview, and record review, the facility failed to ensure a resident's plan of care was followed for 1 of 4 resident care plans reviewed. A resident did not receive care from at least 2 staff members according to the resident's plan of care, resulting in an allegation of staff negligence. (Resident B)</p> <p>Finding includes:</p> <p>During an observation and interview on 4/19/24 at 10:50 A.M., Resident B indicated that he had recently been hospitalized and received a feeding tube after nursing staff had administered his medications orally while Resident B was lying flat in bed, causing a medication to get stuck in the resident's throat and burn a hole in his throat. During the interview, Resident B was sitting up in a wheelchair, eating ice chips. On two occasions the resident had trouble swallowing the ice and began coughing.</p> <p>During record review on 4/18/24 at 11:30 A.M., Resident B's diagnoses included, but was not limited to, cerebral infarction, dysphagia, cognitive communication deficit, and hemiplegia.</p> <p>Resident B's most recent Quarterly MDS (Minimum Data Set) assessment, dated 3/29/24 included that the resident had moderate cognitive impairment, one sided impairment to both upper and lower extremities, was dependent with changes in positioning, including lying to sitting, and had a feeding tube.</p> <p>Resident B's physician orders included, but were not limited to consistent carbohydrate diet, regular texture and regular consistency (discontinued 2/16/24).</p> <p>Resident B's care plan included, but was not limited to, resident requires bolus tube feeding due to dysphagia (initiated 2/26/24), resident is at risk for aspiration related to dysphagia (initiated 1/27/22), and resident reported to fabricate stories about employees. When in resident room, ensure there are two staff in room (initiated 9/7/22).</p> <p>Resident B's nurse's progress notes included the following:</p> <p>2/16/24 at 2:24 P.M., Resident coughed on pill, it got stuck and dissolved in back of throat causing resident to produce a lot of phlegm. Lungs congested, resident continued to cough as day went on. Order given to send to emergency department for evaluation.</p> <p>2/24/24 at 2:59 P.M., Resident returned from hospital. Resident is on an NPO (Nothing by Mouth) diet and gets feeding via PEG (Percutaneous Endoscopic Gastrostomy) tube.</p> <p>(continued on next page)</p>		

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<p>F 0656</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>During a review of the facility's investigation into the incident on 2/16/24, an undated telephone interview with QMA 10 included that the QMA went into Resident B's room for morning medication pass, elevated the resident's bed so his head was up, then Resident B took his pills whole one at a time. Resident B told QMA 10 that he felt like a pill was stuck in his throat. QMA 10 gave Resident B more water and encouraged him to clear his throat. QMA 10 reported to the nurse on duty that the resident reported difficulty with pill. QMA 10 indicated continuing to check on Resident B frequently and that the resident has had trouble with swallowing and choking in the past.</p> <p>During an interview on 4/19/24 at 10:30 A.M., ST 7 (Speech Therapist) indicated that Resident B had aspirated on oral medications on 2/16/24. ST 7 indicated that Resident B had waved to her as she passed his room around noon on 2/16/24 to tell her he had a pill stuck in his throat. Resident B indicated that nursing staff had given him his medications while lying flat causing the pill to become stuck in his throat. ST 7 indicated the staff member denied giving the resident his medications while lying flat.</p> <p>During an interview on 4/19/24 at 12:38 P.M., LPN 9 indicated that 2 staff should be present when providing care to Resident B due to behaviors.</p> <p>During an interview on 4/19/24 at 2:50 P.M., the Facility Administrator indicated that there were not any other witnesses to confirm or deny that Resident B had been administered medications while lying flat on 2/16/24.</p> <p>On 4/19/24 at 3:20 P.M., the Facility Administrator supplied a facility policy titled Comprehensive Care Plan, dated 11/28/12. The policy included, .The facility will develop and implement a comprehensive person-centered care plan for each resident, consistent with the resident rights, that includes measurable objectives and timeframes to meet a resident's medical, nursing, and mental and psychosocial needs .</p> <p>This citation is related to complaint IN00431340.</p> <p>3.1-35(g)(1)</p>		

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<p>F 0677</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Provide care and assistance to perform activities of daily living for any resident who is unable.</p> <p>39130</p> <p>Based on observation, interview, and record review, the facility failed to provide assistance with bathing for 2 of 3 residents reviewed for activities of daily living (ADLs). Residents did not receive assistance with ADL's (bathing) according to the plan of care and bathing schedule. (Resident B, Resident C)</p> <p>Findings include:</p> <p>1. During an observation on 4/19/24 at 10:50 A.M., Resident B was sitting up in a wheelchair. Resident B had multiple stains on the front of his shirt.</p> <p>During an interview on 4/19/24 at 12:45 P.M., Resident B's family member indicated that Resident B had went 23 days while only receiving two showers. Resident B had yeast growing in the palm of his left hand.</p> <p>During record review on 4/18/24 at 11:30 A.M., Resident B's diagnoses included, but was not limited to, cerebral infarction, cognitive communication deficit, and hemiplegia.</p> <p>Resident B's most recent Quarterly MDS (Minimum Data Set) assessment, dated 3/29/24 included that the resident had moderate cognitive impairment, one sided impairment to both upper and lower extremities, and was dependent with bathing.</p> <p>Resident B's care plan included but was not limited to, self care deficit: ADLs. Residents ADL needs will be met by staff with assistance from resident as tolerated. Interventions included, but were not limited to, Shower days per resident preference.</p> <p>Resident B's scheduled shower days were Mondays and Thursdays.</p> <p>During review of Resident B's documented bathing from 3/19/24 thru 4/19/24, the following showers/complete bed baths were provided: Shower on 3/21/24, bed bath on 3/25/24 and 3/28/24, and a shower on 4/18/24.</p> <p>2. During an observation on 4/19/24 at 11:05 A.M., Resident C was sitting up in a recliner with his eyes closed. A soiled towel was on the floor in front of the resident's recliner.</p> <p>During record review on 4/19/24 at 10:00 A.M., Resident C's diagnoses included, but were not limited to, nontraumatic intracranial hemorrhage, difficulty in walking, nausea with vomiting, morbid obesity, and major depressive disorder.</p> <p>Resident C's most recent Quarterly MDS (Minimum Data Set), dated 4/5/24, included that the resident had no cognitive impairment and required substantial to maximum assistance with bathing.</p> <p>Resident C's care plan included but was not limited to, self care deficit: ADLs. Residents ADL needs will be met by staff with assistance from resident as tolerated. Interventions included but were not limited to, shower days per resident preference (initiated 1/17/24).</p> <p>(continued on next page)</p>		

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<p>F 0677</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>During review of Resident C's documented bathing from 3/19/24 thru 4/19/24, the following showers/complete bed baths were provided: Resident refused bathing on 3/26/24, bed bath on 3/29/24, shower 4/5/24, shower 4/12/24, and a shower on 4/16/24.</p> <p>During an interview on 4/19/24 at 1:35 P.M., CNA 4 indicated all residents should receive a complete bed bath or a shower, per their preference, at least twice weekly. Staff should offer bathing on the residents' scheduled shower days and document in the residents' record the type of bathing that occurred. Should the resident refuse their bathing, staff should document the refusal.</p> <p>On 4/19/24 at 4:40 P.M., the Facility Administrator supplied a facility policy titled, Bathing - Shower and Tub Bath, dated 1/31/18. The policy included, .A shower, tub bath, or bed/sponge bath will be offered according to resident's preference two times per week or according to the resident's preferred frequency and as needed or requested .</p> <p>This citation is related to complaint IN00431340.</p> <p>3.1-38(b)(2)</p>		