

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 08/16/2024
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 0690</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Provide appropriate care for residents who are continent or incontinent of bowel/bladder, appropriate catheter care, and appropriate care to prevent urinary tract infections.</p> <p>39130</p> <p>Based on observation, interview, and record review, the facility failed to ensure routine catheter care and ostomy care was completed for 3 of 3 residents reviewed for catheter/ostomy care. Routine catheter and ostomy care was not provided per the residents' plan of care. (Resident C, Resident D, Resident F)</p> <p>Finding includes:</p> <p>1. Resident C was observed up in a wheelchair in her room on 8/16/24 at 10:00 A.M A catheter drainage bag was clipped to the underside of the resident's wheelchair. Resident C indicated that she also had a colostomy and that she had recently waited through multiple shifts for nursing staff to change the colostomy bag.</p> <p>A record review on 8/16/24 at 10:30 A.M., indicated that Resident C's diagnoses included, but were not limited to, paraplegia, neuromuscular dysfunction of bladder, and stage 4 pressure ulcer of sacral region.</p> <p>Resident C's most recent Quarterly Minimum Data Set (MDS) Assessment, dated 6/1/24, indicated the resident had no cognitive impairment, had an indwelling catheter, and an ostomy.</p> <p>Resident C's physician orders included, but were not limited to, catheter care every shift (2/20/24), and colostomy care every shift (2/20/24).</p> <p>Resident C's care plan included, but was not limited to, resident has indwelling catheter due to neuromuscular dysfunction with an intervention including catheter care per policy (12/1/21) and resident has colostomy with an intervention that included empty colostomy bag every shift (12/2/21).</p> <p>Resident C's treatment administration record (TAR) for July, 2024 indicated that the physician's orders to provide catheter care and colostomy care every shift was not documented as completed on 7/6/24 (day-shift), 7/9/24 (nightshift), and 7/15/24 (night shift).</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 0690</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>2. Resident D was observed lying in bed in his room on 8/16/24 at 12:00 P.M. A catheter drainage bag was clipped to the side of the bed. Resident D indicated that he fills the drainage bag often and has to tell staff to empty due to staff not emptying the catheter routinely. Resident D indicated staff rarely come in to provide catheter care including cleaning the catheter tubing and insertion site.</p> <p>A record review on 8/16/24 at 12:30 P.M., indicated that Resident D's diagnoses included, but were not limited to, benign prostatic hyperplasia with lower urinary tract symptoms and neuromuscular dysfunction of bladder.</p> <p>Resident D's most recent Quarterly MDS Assessment, dated 8/7/24, indicated the resident had no cognitive impairment and had an indwelling catheter.</p> <p>Resident D's physician orders included, but were not limited to, catheter care every shift (1/29/24).</p> <p>Resident D's care plan included, but was not limited to, resident has indwelling catheter due to neuromuscular dysfunction with an intervention including catheter care every shift (2/11/24).</p> <p>Resident D's treatment administration record (TAR) for July & August, 2024 indicated that the physician's orders to provide catheter care every shift was not documented as completed on 7/6/24 (day-shift), 8/3/24 (evening shift), 8/7/24 (day-shift), 8/8/24 (day shift), and 8/12/24 (evening shift).</p> <p>3. Resident F was observed sitting up in recliner in her room on 8/15/24 at 11:10 A.M A catheter drainage bag was clipped to the lower leg. Resident F indicated that she provides her own catheter care.</p> <p>A record review on 8/16/24 at 10:50 A.M., indicated that Resident F's diagnoses included, but were not limited to, hemiplegia, chronic kidney disease, and cystocele.</p> <p>Resident F's most recent Quarterly Minimum Data Set (MDS) Assessment, dated 6/24/24, indicated the resident had moderately impaired cognition, an indwelling catheter, and required substantial to maximum assist with toileting hygiene.</p> <p>Resident F's physician orders included, but were not limited to, ensure Foley catheter care is provided every shift (3/31/23).</p> <p>Resident F's care plan included, but was not limited to, resident has indwelling catheter due to cystocele/prolapsed bladder with an intervention including catheter care every shift (4/3/23).</p> <p>Resident F's treatment administration record (TAR) for July, 2024 indicated that the physician's orders to provide catheter care and colostomy care every shift was not documented as completed on 7/6/24 (day-shift), 7/9/24 (nightshift), and 7/15/24 (night shift).</p> <p>During an interview on 8/16/24 at 12:15 P.M., RN 5 indicated staff assist Resident F with her catheter care and that routine catheter care included cleaning the catheter tubing and insertion site. RN 5 indicated if a routine order is not completed, staff should document in the resident's record why the order was unable to be completed.</p> <p>(continued on next page)</p>		

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<p>F 0690</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>On 8/16/24 at 1:10 P.M., the Facility Administrator supplied a copy of an undated facility policy titled Colostomy Care, and a policy titled Urinary Catheter Care, dated 2/14/19. The Colostomy Care policy included, .Colostomy Site Care a) Colostomy site care will be provided . as ordered by [Medical Doctor]. The Urinary Catheter Care policy included, .routine hygiene is appropriate .</p> <p>This citation relates to complaints IN00439625 and IN00439414.</p> <p>3.1-41(a)(2)</p> <p>3.1-47(a)(3)</p>		

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<p>F 0921</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Some</p>	<p>Make sure that the nursing home area is safe, easy to use, clean and comfortable for residents, staff and the public.</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 a safe, sanitary, and homelike environment in 3 of 4 resident halls observed and 2 of 3 shared restrooms observed. Resident rooms were missing window trim, had stained toilet bowls, and were missing thresholds between doorways, shared shower rooms were missing light covers, cove base, corner trim, had cracked or broken tiles, had a broken switch plate, and had old screw holes in the walls, and hall floors were missing baseboard and had worn spots and paint splatters. (C/D Halls and shower rooms, GHI shower room, room [ROOM NUMBER], room [ROOM NUMBER], room [ROOM NUMBER], room [ROOM NUMBER])</p> <p>Findings includes:</p> <ol style="list-style-type: none"> 1. During an observation on 8/15/24 at 11:00 A.M., room [ROOM NUMBER]'s restroom contained a stained commode with the bowl having dark discolorization. 2. During an observation on 8/15/24 at 11:15 A.M., Hall D was observed to have white paint splatters on the hallway floor as well as what appeared to be worn spots through the flooring showing the white spots throughout the hall. Baseboard was missing from room [ROOM NUMBER] to the next doorway of a storage closet. 3. During an observation on 8/15/24 at 11:30 A.M., a shared shower room on the C/D halls contained broken floor tiles near the base of the sink and in the main shower stall. 4. During an observation on 8/15/24 at 2:20 P.M., a second shared room on the C/D halls contained a broken switch plate and a build up of dust in the overhead vent. 5. During an observation on 8/15/24 at 2:40 P.M., a shared shower room on the G/H/I halls was missing a corner trim cover near the commode, had 14 old screw holes on the wall across from the commode, light covers were missing from the light fixtures towards the back of the shower room over a shower stall and towards the front of the room near the doorway, and the wall cove base was missing near the shower room door. 6. During an observation on 8/16/24 at 10:00 A.M., room [ROOM NUMBER] was missing a piece of window trim and the edges of the tiles were cracked or broken near the bathroom door. 7. During an observation on 8/16/24 at 10:30 A.M., room [ROOM NUMBER] and room [ROOM NUMBER] were missing the threshold in the doorways entering the rooms. <p>During an interview on 8/16/24 at 10:15 A.M., Maintenance 4 indicated that the facility was short on maintenance personnel and that one maintenance staff had recently left employment. Maintenance 4 indicated that maintenance staff completes routine checks on rooms weekly but rely on staff to alert them of missing or broken items in the facility. The white spots on the flooring on the C/D hall were from the floor tech staying in one spot too long with the floor cleaning machine and burning through the top layer of flooring.</p> <p>(continued on next page)</p>

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<p>F 0921</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Some</p>	<p>On 8/16/24 at 10:50 A.M., the Facility Administrator supplied an undated facility policy titled Physical Plant - Daily Inspections. The policy included, Buildings and grounds are to be inspected daily . As areas needing repair or attention are identified, they should be dealt with immediately .</p> <p>This citation relates to complaint IN00437748.</p> <p>3.1-19(a)(4)</p>		