

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 12/06/2024
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 0812</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Some</p>	<p>Procure food from sources approved or considered satisfactory and store, prepare, distribute and serve food in accordance with professional standards.</p> <p>39130</p> <p>Based on observation, interview, and record review, the facility failed to ensure a sanitary environment was maintained in accordance with professional standards for food services safety during 2 of 2 kitchen observations. Kitchen staffs' hair was not fully contained within a hairnet, and kitchen staff failed to complete proper hand hygiene.</p> <p>Findings include:</p> <p>1. During an observation on 12/4/24 at 12:00 P.M. the DM (Dietary Manager) was in the kitchen wearing a hairnet. The DM's hair was not fully contained by the hairnet with loose strands of hair coming out the front and back of the hairnet.</p> <p>During an observation on 12/5/24 at 12:00 P.M., the DM and [NAME] 4 were preparing for lunch service. During service, the DM and [NAME] 4's hair was not fully contained by their hairnet with loose strands exposed.</p> <p>During an interview on 12/5/24 at 3:40 P.M., the Facility Administrator indicated she had previously mentioned to the DM that her hair must be covered by the hairnet.</p> <p>2. During a kitchen observation on 12/5/24 at 11:59 A.M., a printed sign above the kitchen handwashing sink indicated that proper hand washing included washing hands for at least 20 seconds.</p> <p>During an observation on 12/5/24 at 12:02 P.M., prior to food service, cook 4 washed hands with a 9 second scrub time.</p> <p>During an observation on 12/5/24/at 12:03 P.M., the DM washed hands with a scrub time of 6 seconds.</p> <p>During an observation on 12/5/24 at 12:04 P.M., the DM exited the kitchen and then returned with a bowl of ice. The DM then washed hands while allowing no scrub time between adding soap to her hands and then immediately rinsing the soap from her hands.</p> <p>During an observation and interview on 12/6/24 at 2:20 P.M., CNA 5 was pushing a food cart and hydration cart through the GHI dining room. CNA 4 indicated that during meal service, staff should wash their hands for a time period long enough to sing the alphabet twice.</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 0812</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Some</p>	<p>On 12/6/24 at 10:00 A.M., the Facility Administrator supplied a facility policy titled, Hair Restraints, dated 2020. The policy included, Hair restraints shall be worn by all Dining Services staff when in food production areas, dishwashing area, or when serving food . The Facility Administrator also supplied a policy titled, Proper Hand Washing and Glove Use, dated 2020. The policy included, 1. Instructions will be posted over each hand washing station outlining the proper procedure for washing hands. 2. The proper procedure for washing hands is as follows: a. Turn on water as hot as comfortable. b. Wet hands and apply soap. c. Scrub for 15 to 20 seconds or more: getting under nails, between fingers, and all exposed areas, such as back of hands and forearms . 3. All employees will wash hands upon entering the kitchen from any other location . 4. Employees will wash hands before and after handling foods .</p> <p>This citation relates to complaints IN00448562, IN00447164, and IN00442047.</p> <p>3.1-21(i)(2)</p> <p>3.1-21(i)(3)</p>		

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<p>F 0842</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Safeguard resident-identifiable information and/or maintain medical records on each resident that are in accordance with accepted professional standards.</p> <p>39130</p> <p>Based on interview and record review, the facility failed to ensure resident records were accurate and complete for 1 of 3 residents reviewed for pressure wounds and 1 of 3 residents reviewed for diabetic care. Medication Administration Records (MAR) and Treatment Administration Records (TAR) were not documented completely. (Resident D)</p> <p>Finding includes:</p> <p>During record review on 12/6/24 at 10:30 P.M., Resident D's diagnoses included, but were not limited to, diabetes mellitus, morbid obesity, and chronic kidney disease.</p> <p>Resident D's most recent quarterly Minimum Data Set (MDS) assessment dated , 11/8/24, indicated the resident received insulin.</p> <p>Resident D's care plan included, but was not limited to, Resident has a left toe infection (created 9/30/24) and resident has diabetes mellitus (created 12/18/20).</p> <p>Resident D's physician orders included, but were not limited to, treatment to left, first toe. Cleanse area with wound cleanser or normal saline solution, pat dry. Apply Betadine twice a day and as needed, every day and night shift (started 10/17/24), and Humalog Injection (insulin) Solution 100 units/milliliter (ml) inject per sliding scale (started 12/8/23).</p> <p>A review of Resident D's TAR indicated that the resident's order for wound treatment to the left toe was not documented as completed, and contained no documentation as to why it was not completed on the dates of: 10/27/24 (day shift), 11/18/24 (day shift), 11/20/24 (day shift), 11/21/24 (day shift), 11/23/24 (day shift), and 12/2/24 (day shift).</p> <p>A review of Resident D's MAR indicated that the resident's order for sliding scale insulin was not documented as administered and contained no documentation as to why the medication was not administered. The record also lacked required documented blood sugar levels for the following dates in November, 2024: 11/6/24 (evening), 11/13/24 (noon), 11/23/24 (noon).</p> <p>During an interview on 12/6/24 at 2:20 P.M., LPN 9 indicated that all ordered medications and treatments should be documented as completed in the resident's MAR and TAR. When an ordered medication or treatment is not administered or completed, staff should document the reasoning.</p> <p>On 12/6/24 at 3:15 P.M., the Facility Administrator supplied an undated facility policy titled Medication Administration General Guidelines. The policy included, .Documentation (including electronic) 1. The individual who administers the medication dose records the administration on the resident's MAR directly after the medication is given . 6. If a dose of regularly scheduled medication is withheld, refused, not available, or given at a time other than the scheduled time . An explanatory note is entered .</p> <p>(continued on next page)</p>		

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<p>F 0842</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>3.1-50(a)(1)</p> <p>3.1-50(a)(2)</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 2 of 6 resident halls observed. Resident areas had holes in walls, floors appeared dirty and unmopped, bedpans were stored uncovered, cove base was missing from a resident restroom, a vent fan was missing a cover in a resident restroom, used Styrofoam cups were not removed from a resident's room, and resident wheelchairs had not been cleaned. (C/D Halls, Resident D, Resident F, room [ROOM NUMBER], room [ROOM NUMBER], Resident H, Resident G, Resident M)</p> <p>Finding includes:</p> <p>1. During a review of facility grievance forms on 12/4/24 at 1:30 P.M., a concern/complaint form dated 12/1/24 indicated that a family member to a resident in room [ROOM NUMBER] made staff aware that the resident had not had any housekeeping services in days and had been out of toilet paper for days. Family indicated the room was filthy.</p> <p>During a review of resident council minutes on 12/4/24 at 1:40 P.M., a council meeting held 9/25/24 indicated that residents were requesting that their restrooms be deep cleaned better. A council meeting held 11/26/24 indicated a resident was concerned with their commode not being cleaned and their restroom floor not being swept and mopped.</p> <p>During an interview on 12/5/24 at 3:30 P.M., Resident H's family member indicated that the resident had gone days without housekeeping services just a few days prior in room [ROOM NUMBER]. The family member indicated that the resident was out of toilet paper and that the waste bin had not been emptied. The resident used a walker to get around that had tennis balls placed on the bottom to help the walker move across the floor. The tennis balls were covered in dust from the floor not being cleaned.</p> <p>2. During an observation on 12/4/24 at 3:07 P.M., Resident D had 5 Styrofoam drinking cups on a bedside table, one the cups was dated 12/2/24.</p> <p>During an observation on 12/5/24 at 11:05 A.M., room [ROOM NUMBER]'s restroom was observed to have no functioning light. A bedpan was sitting on top of a wheel chair in the restroom uncovered and contained a brown substance. A wet washcloth was lying in the restroom sink. A hole was located near the door to the restroom. During an interview, Resident D indicated that he did not typically go into the restroom and used a bedpan, and that staff used the restroom to wash their hands.</p> <p>During an observation on 12/6/24 at 10:35 A.M., Resident D's restroom light was not functioning and a hole remained in the wall near the restroom door.</p> <p>3. During an observation on 12/5/24 at 11:10 A.M., Resident F's restroom contained no cove base, a bedpan was uncovered and resting on the back of the commode, the vent fan was missing a cover, toothpaste was on the wall behind the sink, and white splatter marks were on the wall next to the sink.</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>During an observation on 12/6/24 at 10:50 A.M., Resident F's restroom had no cove base, a bedpan was resting on the back of the commode uncovered, the vent fan had no cover, and white splatters remained on the wall next to the sink.</p> <p>4. During an observation on 12/5/24 at 11:12 A.M., a common area on Hall D appeared to be unmopped with wheelchair markings crossing the floor and a brown drip stain on the floor near a television.</p> <p>During an observation on 12/6/24 at 10:40 A.M., a common area on Hall D appeared to be unmopped with wheelchair markings crossing the floor and a brown drip stain on the floor near a television.</p> <p>5. During an observation on 12/5/24 at 11:15 A.M., the wall between a utility closet and room [ROOM NUMBER] on the C hall had a hole punctured in it.</p> <p>During an observation on 12/6/24 at 10:45 A.M., the wall between a utility closet and room [ROOM NUMBER] on the C hall had a hole punctured in it.</p> <p>6. During an interview an observation on 12/6/24 at 2:55 P.M., Resident G and Resident M indicated that their wheelchairs are never cleaned and that housekeeping did not clean their rooms routinely. Resident G and Resident M's wheelchair wheels were covered in dust. Resident G had a cup holder attached to the wheelchair that had old spills inside of it that had not been cleaned.</p> <p>During an interview on 12/6/24 at 11:45 A.M., LPN 9 indicated that bedpans should be cleaned when not in use and covered when stored.</p> <p>During an interview on 12/6/24 at 1:40 P.M., the Maintenance Director indicated that they are behind on the maintenance work that needs to be completed and that they could use extra maintenance staff, at least temporarily, to catch up with the work needed to be done.</p> <p>During an interview on 12/6/24 at 3:15 P.M., the Facility Administrator indicated that night shift should be cleaning resident wheelchairs but that no wheelchair cleaning schedule existed at that time. The Facility Administrator indicated she would make a cleaning schedule for the resident wheelchairs.</p> <p>On 12/6/24 at 2:10 P.M., the Facility Administrator supplied an undated C Hallway Daily Cleaning Log. The Facility Administrator indicated that the cleaning log applied to all resident halls, no just the C hall. The log included that resident rooms would have the trash collected, toilet cleaned, and floors would be swept and mopped daily.</p> <p>This citation relates to complaints IN00448562 and IN00446746.</p> <p>3.1-19(a)(4)</p>		