STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	155042	A. Building B. Wing	09/23/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Aperion Care Vincennes	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)
F 0689 Level of Harm - Actual harm Residents Affected - Few	Ensure that a nursing home area is free from accident hazards and provides adequate supervision to prevent accidents. (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 - Actual harm Residents Affected - Few	Based on observation, interview, and record review, the facility failed to ensure a resident was free from accident hazards for 1 of 3 residents reviewed for accidents. Staff provided hot water to a resident without monitoring or checking the temperature of the water. The resident spilled the hot water which resulted in second-degree burns to the resident's abdomen, left hip, and lower back. This deficient practice resulted from a failure to follow the facility's procedure for serving hot beverages and contributed the development of second-degree burns that required routine treatment and the resident pain rated at a 5 on a scale of 0 - 10 (zero indicating no pain and 10 indicating the most pain). (Resident C)Finding includes: During a review of Facility Reported Incidents (FRIs) on 9/17/25 at 1:50 P.M., an incident dated 9/13/25 at 10:01 P.M. indicated Resident C had requested that CNA 4 heat a cup of water. CNA 4 placed the heated water on a bedside table, and Resident C spilled the water onto herself when raising her head of bed. Resident C received second-degree burns to her abdomen and back. During an observation and interview on 9/17/25 at 2:50 P.M. , Resident C was sitting up in a Broda wheelchair in her room. Resident C indicated that she recently sustained second-degree burns from a spilled hot water after staff had brought her boiling hot water that had been warmed in a microwave. The resident indicated she often liked to make instant coffee in the evening. Resident C provided images of the burn wounds that included 3 separate reddened areas with what appeared to be a peeling off of the outer layer of skin. During record review on 9/17/25 at 3:00 P.M., 2/26/25 at 11:15 A.M., Resident C's diagnoses included, but were not limited to, spastic paraplegia, demyelinating disease of the central nervous system, hypertrophic osteoarthropathy, cerebellar ataxia, lack of coordination, and muscle spasm.Resident C's most recent Annual Minimum Data Set (MDS) assessment, dated 9/2/25, indicated the resident had no cognitive impairment, had lower extremity impairment to both sides, and required setup assistance for eating.Resident C's care plan included, but was not limited to, Activity of Daily Living (ADL) self-care/mobility performance (functional abilities) deficit that may fluctuate with activity throughoutthe day due to limited mobility, limited Range of Motion (ROM), and musculoskeletal impairment (initiated 3/07/2025). Interventions included but were not limited to set up assistance for eating (revised 6/16/25). Resident C's physician orders included, but were not limited to: Silver sulfadiazine external cream 1%, apply to trunk and lower back topically two times a day for burns (started 9/14/25) and treatment to hip, abdomen and left flank, gently cleanse areas with normal saline, apply Silvadene, cover with non-adherent dressing and secure with rolled gauze every day shift for burn and as needed if soiled or dislodged (started 9/18/25). Resident C's progress notes included, but were not limited to:9/14/25 at 2:30 P.M. - Follow-up assessment of burn - Burn areas continue to be red with large blisters noted to the abdomen, under both breasts, lower back, and left outer thigh. Silvadene treatment applied. 9/15/25 at 6:33 A.M. - CNAs reported a skin issue to the nurse. Resident C stated that the night shift CNA had been asked to heat up a cup of water for the resident to make instant coffee in her room. The resident states that the CNA told her she had heated the cup of water for two and a half minutes. The resident raised the head of the bed with her remote control, and the cup of hot water was knocked over and spilled on the resident's torso and traveled to her back. Skin was red, and blisters were noted forming. The physician was notified, and orders were received to send to the hospital. The area was draped with a cool compress.9/15/25 at 9:57 A.M. - Blistering present at burn site. Some blisters open. Resident C's wound assessments included, but were not limited to the following:9/15/2025 1:24 PM - abdomen, facility acquired burn, partial thickness, wound tissue intact skin 20%, pale pink or red epithelial 20%, bright pink or red 60%, pain rated at 5 on scaled 0 - 10 (0 being no pain and 10 being the most pain), wound measurement 34 cm (centimeters) x 10 cm x 0.10 cm (L x W x D). 9/15/2025 1:28 PM - left side lower back, facility-acquired burn, partial thickness, wound tissue intact skin 15%, pale pink non-granulating 15%, bright pink or red 70%, pain rated at 5 on scale 0 - 10, wound measurement 19 cm x 12 cm x 0.10 cm.9/16/25 at 7:19 A.M. - Left trochanter (hip), facility-acquired burn, partial thickness, wound tissue 100% bright pink or red, pain rated at 4 on scale 0 - 10, wound measurement 15 cm x 8 cm x 0.10 cm.During an interview on 9/18/25 at 10:55 A.M., the Director of Nursing (DON) indicated that staff should monitor the temperature of heated liquids that are served to residents and that there was no documentation or indication that the temperature of the water served to Resident C was monitored. The DON indicated education was provided to staff regarding water/drinking temperatures, thermometers were provided near microwaves, and signage to remind staff to monitor temperatures had been added in the dining areas near microwaves. On 9/18/25 at 11:06 A.M., the Facility Administrator

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F 0921 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Make sure that the nursing home area is safe, easy to use, clean and comfortable for residents, staff and the public. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, interview, and record review, the facility failed to ensure a safe, sanitary, and homelike environment in 1 of 3 resident units observed and 1 of 2 dining rooms observed. Resident areas had missing paint on the walls, missing cove base, plywood covering a window, and a dark decolorization to dining room vaulted ceiling. (C/D halls, room [ROOM NUMBER], room [ROOM NUMBER] and C/D dining room)Finding includes:During an observation on 9/17/25 at 11:35 A.M., Resident room [ROOM NUMBER] was missing paint from the wall under the window, around the air conditioning unit, and behind the bed. The cove base behind the resident bed was missing from the wall. An observation on 9/17/25 at 11:38 A.M., Resident room [ROOM NUMBER] had a piece of plywood completely covering 1 of 2 windows in the room. An observation on 9/17/25 at 11:40 A.M., a shared restroom door near the nurse's station on the C/D hall unit had a protective door covering that had peeled away from the door, approximately 5 inches from the top right corner, approximately halfway up the door. An observation on 9/23/25 at 12:08 P.M., the C/D unit dining room contained an activity area with a television and dividing half wall. Approximately 80 % of the paint had peeled off the wall. The vaulted ceiling had a black discoloration near the top of the ceiling. An observation on 9/23/25 at 12:14 P.M., Resident room [ROOM NUMBER] was missing paint from the wall under the window, around the air conditioning unit, and behind the bed. The cove base behind the resident bed was missing from the wall. During an interview on 9/23/25 at 1:00 P.M., the maintenance director indicated that when residents move out of their room, the room is then repaired and renovated. The maintenance director indicated that he had been at the facility for approximately four weeks and the facility was soon hiring an assistant maintenance personnel. The window in room [ROOM NUMBER] had been broken by a lawnmower, and the facility was waiting on a repair window, and an outside source was scheduled to be at the facility the following day to bid on the work for the dining room. Facility maintenance could not complete the larger projects and required outside sources to make those repairs. On 9/23/25 1:30 P.M., The Facility Administrator supplied an undated facility policy titled Environmental Services Policy. The policy included, Purpose: To ensure that the facility is designed, equipped, and maintained in accordance with all governing rules and regulations and standards . It is the policy of the facility that it is constructed, equipped, and maintained to carry out the function of all services and to protect the health and safety of residents, personnel, public, and in compliance with all applicable Federal, State, and Local regulations.This citation relates to intakes 2603099, 2600442, and 2596108. 3.1-19(a)(4)