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	10/22/2025

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 0849 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Arrange for the provision of hospice services or assist the resident in transferring to a facility that will arrange for the provision of hospice services. (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

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
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F 0849 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on interview and record review, the facility failed to ensure residents received end of life care for 2 of 3 residents reviewed for hospice care. A collaborative plan of care was not established for residents who received hospice services and routine assessments, and physician orders were not completed. (Resident B, Resident C)1. During record review on 10/20/25 at 1:15 P.M., Resident B's diagnoses included but were not limited to chronic kidney disease and malignant cancer. Resident B's most recent Minimum Data Set (MDS) assessment, dated 9/3/25, indicated the resident had not received hospice services. Resident B's physician orders included Lorazepam 0.5 milligrams (mg) one tablet every three hours as needed for anxiety (started 10/6/25 at 8:00 P.M.) and morphine sulfate solution 20 milligrams/milliliter (mg/ml) give 0.5 ml every hour as needed for pain or shortness of breath (started 10/6/25 at 7:49 P.M.), and oxygen at 2 liters per nasal cannula continuously to keep saturation level above 90% every shift for shortness of breath (started 10/7/25). All routine medications had been discontinued.Resident B's nurse's progress notes included, but were not limited to:9/29/25 at 8:50 P.M. - Resident was sent to the hospital.10/6/25 at 2:10 P.M. - Resident admitted back to the facility from the hospital. Resident to be admitted to hospice. Spouse with the resident at bedside. Hospice was notified of the arrival. 10/7/25 at 6:00 A.M. - Resident nonresponsive. No pulse, no respirations. Death verified with a Registered Nurse (RN). Hospice notified.Resident B's Hospice Visit Note Report dated 10/6/25 indicated Hospice services arrived at the facility at 5:44 P.M. and completed assessments at 6:46 P.M. Resident B's pain was rated at a 2 on a scale of 0-10 (0 being no pain and 10 being the worst pain), and the resident's oxygen level was 97 % on 2 liters of oxygen. A visit narrative indicated the resident had a terminal diagnosis of prostate cancer and wished to pass comfortably. Resident B was minimally responsive. The resident depends on the caregiver for all activities of daily living (ADLs). Hospice interventions included: 1. Instruct patient/caregiver(s) how to monitor pain using an appropriate pain scale 2. Instruct administration and side effects of pain medications. 11. Assess signs/ symptoms of death and dying. The Visit Note Report indicated the in-facility visit concluded on 10/6/25 at 6:52 A.M.Resident B's documented vital signs indicated the resident's last documented oxygen saturation levels were assessed at the facility on 10/6/25 at 5:08 P.M. at 95% and 10/6/25 at 6:57 at 87% on room air. Resident B's record contained no further documented assessments of pain, discomfort, restlessness, or oxygen saturation. A Braden Scale observation was completed 10/6/25 at 8:32 P.M., and a Fall Risk Assessment was completed at 8:34 P.M. Resident B's Medication Administration Record indicated that no as-needed medications were administered between the time of readmission on [DATE] and the time of death of 10/7/25. During an interview on 10/21/25 at 11:05 A.M, RN 4 indicated a resident on hospice with orders for as-needed medications every one to two hours should be assessed for comfort every 30 minutes to one hour, and that routine observations and assessments should be documented in the resident's record. 2. During record review on 10/21/25 at 10:30 A.M., Resident C's diagnoses included but were not limited to large B-cell lymphoma lymph nodes of multiple sites. Resident C's most recent MDS dated [DATE] indicated the resident was not receiving hospice care. Resident C's physician orders included, but were not limited to, pain assessments every shift (started 9/9/25), Admit to hospice (started 9/17/25), supplemental oxygen at 2 liters per minute as needed for dyspnea/anxiety every shift (started 9/18/25), Lorazepam 0.5 mg every two hours as needed for anxiety/restlessness (started 9/18/25), morphine sulfate concentrate solution 20 mg/ml every 1 hour as needed for shortness of breath/pain (started 9/18/25)Resident C's facility care plan did not include a plan of care regarding hospice services.Resident C's nurse's notes included, but were not limited to the following: 10/6/25 at 4:55 P.M. - Morphine sulfate concentrate administered related to stomach pain.10/6/25 at 11:48 P.M. - Morphine sulfate concentrated administered was effective. Resident sleeping.10/7/25 at 7:20 A.M. - Residents' respirations ceased, no apical pulse auscultated. Resident C's medication administration record/ treatment administration record (MAR/TAR) for October 2025 indicated the resident's oxygen level was not assessed every shift as ordered during the day or night shift of 10/6/25 through 10/7/25. During an interview on 10/22 at 11:25 A.M., RN 6 indicated following the administration of a PRN pain medication, nursing staff should reassess a resident within an hour to monitor if the medication was effective. RN 6 indicated that a resident requiring hospice services should be assessed and monitored more frequently. On 10/21/25 at 2:30 P.M., RN 8 supplied a facility policy titled Hospice Services, dated 11/18/2012. The policy included...The facility will provide hospice services either directly or through arrangements with a qualified