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	05/28/2026

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 0698 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide safe, appropriate dialysis care/services for a resident who requires such services. Based on observation, interview, and record review, the facility failed to ensure ongoing communication was maintained for 1 of 2 resident reviewed for dialysis services. Dialysis communication forms or any other documented dialysis visit notes could not be retrieved by the facility and Director of Nursing was not aware that the dialysis center had changed a resident's prescribed dialysis schedule from three (3) days per week to two (2) days per week. (Resident B)Finding includes:Resident B's record review on 5/26/26 at 1:30 P.M., indicated the resident's diagnoses included, but were not limited to, end stage renal disease and dependence on renal dialysis.The most recent quarterly Minimum Data Set (MDS) assessment, dated 5/11/26, indicated the resident was cognitively intact and received dialysis services. The care plan included but was not limited to, Resident need dialysis due to renal failure (initiated 11/18/25). Interventions included but were not limited to encourage resident to go to dialysis appointments Monday, Wednesday, and Fridays (initiated 11/18/25). Physician orders included but were not limited to, dialysis treatments three times a week every Monday, Wednesday, and Friday (restarted 5/8/26). Resident B's record contained no dialysis communication forms past the date of 3/202/6. The dialysis communication form on 3/20/26 included instructions for facility staff to monitor fluid intake due to noncompliance with the fluid restriction. Observation on 5/27/26 at 1:25 P.M., Resident B's dialysis communication binder was behind the nurse's station. The binder was empty upon review. Interview on 5/27/26 at 2:00 P.M., LPN 3 indicated dialysis communication forms were used to communicate information such as pre and post dialysis vital signs and any new orders or instructions from the dialysis center. Interview on 5/27/26 at 3:15 P.M., the Facility Administrator indicated the resident's dialysis communication binder had been emptied after the resident passed away on 5/18/26. The Facility Administrator indicated the ambulance service that provided transportation for the resident to and from dialysis also may have had the communication sheets. A handwritten note with dates of dialysis appointments indicated the resident had been scheduled two days per week and often missed dialysis appointments. The Director of Nursing (DON) indicated the dialysis center changed the resident's order from three days per week to two days per week without notifying the facility.On 5/27/26 at 3:38 P.M., the Facility Administrator provided a copy of the dialysis contract, dated 3/9/26 and titled, Nursing Home Dialysis Transfer Agreement. The contract included, .15. Medical Records. Center shall maintain reports of all services rendered by center in accordance with it's usual medical records procedures . Facility shall have the right to photocopy any such reports, records or documents for inclusion in it's own records.On 5/27/26 at 3:58 P.M., the Facility Administrator provided a treatment attendance record from the dialysis center that included scheduled dialysis dates from 3/2/26 through 5/18/26. A noted on the attendance record included, Patient treatments were prescribed two treatments per week on Monday and Friday (morning) .This citation relates to intake 3020811. 410 IAC (Indiana Administrative Code) 16.2-3.1-37(a)

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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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0755 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide pharmaceutical services to meet the needs of each resident and employ or obtain the services of a licensed pharmacist. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on interview and record review, the facility failed to ensure adequate pharmaceutical services were available to provide physician prescribed routine medications to 2 of 3 residents reviewed for pharmacy services. Residents did not receive routine physician prescribed medications due to the medications not being available and new physician prescribed medication was not started timely following a readmission from the hospital. (Resident B, Resident C)Findings include:1. Resident B's record review on 5/26/26 at 1:30 P.M., indicated the resident's diagnoses included, but were not limited to, end stage renal disease, chronic heart failure, cirrhosis of liver, and pneumonia. Physician order's included but were not limited to hydrocodone-acetaminophen 10-325 milligrams (MG) 1 tablet by mouth every 4 hours (started 11/18/25) and amoxicillin 500 MG by mouth two times a day started 5/11/26. The April and May 2026 Medication Administration Records (MAR) indicated the resident did not receive the physician prescribed hydrocodone-acetaminophen 10-325 mg medication order on 4/25/26 at 8:00 A.M., 4:00 P.M., and 8:00 P.M., 4/26/26 at 12:00 A.M., 4/27/26 at 8:00 A.M., 5/1/26 (missed all six administrations), 5/2/26 missed all six administrations, and 5/3/26 at 12:00 A.M. and 4:00 A.M. The order was discontinued on 5/3/26. Nurses progress notes included, but were not limited to:4/25/26 at 4:21 P.M. - Order Administration note regarding hydrocodone-acetaminophen 10-325 milligrams medication - awaiting pharmacy.4/25/26 at 8:10 P.M. - Order Administration note regarding hydrocodone-acetaminophen 10-325 milligrams medication - awaiting pharmacy.4/26/26 at 12:01 A.M. - Order Administration note regarding hydrocodone-acetaminophen 10-325 milligrams medication - awaiting pharmacy.5/1/26 at 1:22 A.M. - Order Administration note regarding hydrocodone-acetaminophen 10-325 milligrams medication - waiting on pharmacy.5/1/26 at 5:05 A.M. - Order Administration note regarding hydrocodone-acetaminophen 10-325 milligrams medication - waiting on pharmacy.5/8/26 at 9:16 P.M. - Resident was readmitted from the hospital this shift. Medications were confirmed. 5/10/26 at 10:35 P.M. - Resident stated that he was to be taking an antibiotic according to the hospital doctor when he was discharged . upon looking into the discharge orders this nurse did not see an order on any of the included pages. Called hospital and was transferred to the physician's line where a message was left for a call back. The nurse on the unit called back and stated that all medication had been faxed to the pharmacy including an antibiotic order.Resident is upset that medication hasn't been given.5/11/26 at 12:34 A.M. - Received original hospital orders and found that the resident is to be on amoxicillin oral capsule 500 MG twice a day for eight days. Hospital Discharge summary, dated [DATE] at 1:30 P.M., included a discharge diagnosis of pneumonia. The hospital course included, Transitioned to oral amoxicillin on discharge . Discharge Medications included, start taking these medications: amoxicillin 500 MG capsule - take 1 capsule (500 mg) by mouth two times daily for eight days. Interview on 5/27/26 at 10:20 A.M., the Director of Nursing (DON) indicated the hospital had originally only sent every other page of Resident B's discharge summary received 5/8/26. The first page of the summary included that the resident should start taking amoxicillin but did not include an order for the mediation with a dosage or frequency. The facility attempted to contact the hospital for clarification. On 5/9/26 a list of medication orders was sent from the hospital, but no order for amoxicillin was included. On 5/10/26 the hospital sent the discharge summary which included the physician's order for amoxicillin. The amoxicillin was started the following day. Interview on 5/27/26 at 2:15 P.M., RN 6 indicated a residents hospital discharge orders should be clarified as soon as possible. Interview on 5/28/26 at 9:55 A.M. the Infection Control Preventionist indicted staff should have documented every attempt to clarify Resident B's antibiotic order from the hospital. 2. Record review on 5/27/26 at 10:30 A.M., indicated Resident C's diagnoses included but were not limited to, polyneuropathy, irritable bowel syndrome, and glaucoma. Physician orders included, but were not limited to pregabalin oral capsule 225 milligrams (MG) two times a day (continued on next page)

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F 0755 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	(started 5/1/26), Artificial Tears ophthalmic solution 0.2-0.2-1 % one drop in both eyes four times a day (started 5/1/26), and diphenoxylate-atropine (Lomotil) oral tablet 2.5-0.025 MG one tablet by mouth three times a day (started 5/1/26).May 2026 Medication Administration Records (MAR) indicated the resident did not receive the physician prescribed medications; pregabalin 225 MG two times a day 5/1/26 through 5/4/26, and on 5/6/26, Artificial Tears one drop in both eyes four times a day was not administered 5/1/26 and 5/9/26, and Lomotil 2.5 - 0.025 MG was not administered 5/1/26 through 5/4/26 and on 5/9/26.Nurse's notes included the following:5/2/26 at 11:01A.M. - Order Administration Note - Diphenoxylate-atropine oral tablet 2.5-0.025 MG pending from pharmacy. Not available in the Emergency Drug Kit (EDK). Physician aware.5/2/26 at 5:36 P.M. - Order Administration Note - Pregabalin oral capsule 225 MG pending from pharmacy, not in EDK, physician aware. 5/3/26 at 7:46 A.M. - Order Administration Note - Pregabalin oral capsule 225 MG pending from pharmacy.5/3/26 at 7:46 A.M. - Order Administration Note - Diphenoxylate-atropine oral tablet 2.5-0.025 MG pending from pharmacy.5/4/26 at 7:58 A.M. - Order Administration Note - Diphenoxylate-atropine oral tablet 2.5-0.025 MG pending from pharmacy.5/4/26 at 7:59 A.M. - Order Administration Note - Pregabalin oral capsule 225 MG pending from pharmacy.5/8/26 at 11:36 A.M. - Order Administration Note - Note Artificial Tears Ophthalmic Solution 0.2-0.2-1 % on order. Physician aware. Interview on 5/28/26 at 10:10 A.M. the Director of Nursing (DON) indicated the facility had been in between pharmacies and during the transition period some resident medications were briefly unavailable, and there had been an issue with insurance coverage for medications when a resident returned from a transfer to another facility. On 5/28/26 at 12:22 P.M., the Facility Administrator supplied a copy of the signed pharmacy contract, titled Pharmacy Services Agreement. The contract included, .effective as of the 6th day of March 2026 . 1.2 Delivery Schedule. The pharmacy agrees to deliver to the facility any prescriptions and supplies seven (7) days per week. All medications will be delivered within reasonable times, except for circumstances and conditions beyond its control . This citation relates to intake 3020811.410 IAC (Indiana Administrative Code) 16.2-3.1-25(a)

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F 0770 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide timely, quality laboratory services/tests to meet the needs of residents. Based on interview and record review, the facility failed to ensure laboratory services were provided for 1 of 3 residents reviewed for quality of care. Labs were not completed per the physician's order. (Resident B)Finding includes:Resident B's record review on 5/26/26 at 1:30 P.M., indicated the resident's diagnoses included, but were not limited to, end stage renal disease, chronic heart failure, cirrhosis of liver, and atrial fibrillation (A-fib). The most recent quarterly minimal data set (MDS) assessment, dated 5/11/26, indicated the resident was cognitively intact and received dialysis services. Physician orders included but were not limited to, Prothrombin Time/ International Normalized Ration - PT/INR (lab test to measure how quickly blood clots) daily for two weeks due to increased results (started 5/13/26). The May 2026 Medication Administration Record / Treatment Administration Record (MAR/TAR) included the PT/INR daily for two weeks order that started on 5/13/26 and indicated the lab test was not completed on 5/15/26, 5/16/26, and 5/17/26. The order was discontinued on 5/18/26. Nurse's notes included but were not limited to the following:5/16/26 at 6:15 P.M. - The lab can't come to facility this weekend to draw resident PT/INR. Physician is aware. 5/17/26 at 7:42 A.M. - The lab can't come out this weekendInterview on 5/27/26 at 10:40 A.M., the Director of Nursing and Facility Administrator indicated the facility's contracted lab service was unrealizable and would only come to the facility once a week to provide lab services. The facility attempted to use a local hospital lab service to complete Resident B's PT/INR lab orders; however the hospital lab staff was unable to come to the facility. On 5/27/26 at 11:03 A.M., the Facility Administrator supplied a copy of an outsourced lab contract, signed and dated 3/20/24. The Laboratory Service Agreement included, This Laboratory Services Agreement . effective as of March 1, 2024 . I. Services. [Lab Company] will travel to Client Locations to draw and/or collect patient specimens for duly ordered tests and will transport the specimens to one of [Lab Company] laboratories for testing all in accordance with the terms of the Laboratory Services Agreement and this Exhibit (or arrange for performance by a duly licensed reference laboratory) . a. Testing ordered on an urgently time sensitive basis (STAT Testing) incurs an additional fee of $30.00 per patient per visit. ST AT Testing is based on the AHA Standard Testing Fee Schedule and is only available for the tests set forth on Schedule I (attached hereto); b. Set-Time Collection fee of $30.00 per requested Set-Time Collection. Set-Time Collection means a request by Facility for one or more patient specimens to be collected at a specific time . STAT Testing Schedule . Hematology & Coagulation . 3. Prothrombin Time (PT/INR) .An interview on 5/27/26 at 2:30 P.M., RN 4 indicated the facility did not have a contract with the hospital lab. This citation relates to intake 3020811. 410 IAC (Indiana Administrative Code) 16.2-3.1-49(a)