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	02/13/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Aperion Care Vincennes	3801 Old Bruceville Road, Box 136 Vincennes, IN 47591

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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 0550 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Honor the resident's right to a dignified existence, self-determination, communication, and to exercise his or her rights. 46416 Based on observation, interview, and record review, the facility failed to ensure each resident was treated with respect and dignity for 2 of 3 residents reviewed for dignity concerns and one random observation. Residents felt like staff were rude and not in a hurry to provide care and staff made unkind comments about a resident within hearing distance of that resident. (Resident C, Resident E, Resident F) Findings include: 1. On 2/10/25 at 10:27 A.M., Resident C's clinical record was reviewed. Diagnoses included, but were not limited to, stroke, hemiplegia on right dominant side, and dementia with mood disturbance. The most recent Annual Minimum Data Set (MDS) assessment, dated 1/8/25, indicated Resident C's cognition was moderately impaired and totally dependent on staff for toileting and transfers. During an observation of incontinence care on 2/11/25 at 1:16 P.M., Resident C indicated night shift staff were rude to her when she asked for ice and asked to get out of bed. She indicated they wouldn't give her ice because she didn't need it and they wouldn't get her up because they were leaving and day shift would get her up. The resident indicated it made her upset and she threw her call light onto the floor. Certified Nurse Aide (CNA) 25 and CNA 27 were both present. After care was completed, CNA 25 indicated to the resident that she had notified the charge nurse and someone should come talk to her about her complaints. During an interview on 2/11/25 at 1:55 P.M., CNA 25 indicated she knew Resident C well and believed she was interviewable. She indicated when she started her shift that day the resident seemed upset and her call light was on the floor. During an interview on 2/12/25 at 9:30 A.M., the Administrator indicated she was aware of the alleged incident, staff investigated it, and she sent an Indiana Department of Health (IDOH) incident report. She said she was not sure it really happened but believed it was agency staff who worked the night before and they were phasing them out anyway. She indicated they would educate staff on providing resident's preferences within reason. 2. On 2/10/25 at 9:37 A.M., Resident E's clinical record was reviewed. Diagnoses included, but were not limited to, stroke, dementia without behaviors, and diabetes mellitus type II. (continued on next page)

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE	TITLE	(X6) DATE

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F 0550 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	The most recent Quarterly MDS assessment, dated 11/8/24, indicated Resident E's cognition was moderately impaired and totally dependent on staff for toileting, bed mobility, and transfers. During an interview on 2/6/25 at 10:44 A.M., Resident E's family member indicated in the evening on 1/5/25 at approximately 7:30 P.M., her brother called her and indicated staff weren't answering his call light. She hung up with him and called the facility to notify staff he needed attention. After hanging up with staff, she indicated she called her brother back to let him know they should be coming. At that time, she said a female staff member confronted her brother and said in a degrading tone, You do not need to call your sister, you should use your call light. The sister and resident were not familiar with the staff member. She indicated she called to report the incident to the SSD on 1/6/25 at approximately 9:48 A.M., but no one answered the phone and she left a general message for the SSD to call her back but she hadn't received a call. She indicated her brother often complained that he had to wait too long for staff to come clean him up. She indicated she had discussed that concern with the Social Services Director (SSD) before but nothing had changed. During an interview on 2/7/25 at 11:10 A.M., Resident E indicated they Have to sit in it too long to the point where it burns and hurts. He indicated he used his call light and there were some staff that come quickly, but some staff Aren't in any hurry. During an interview on 2/13/25 at 9:30 A.M., the SSD indicated he was aware of the incident and spoke with the resident's sister and the resident recently. According to their investigation, Resident E thought he turned on the call light but he didn't. The sister said she was here 20 minutes prior to the incident and his call light was not on at that time. The SSD indicated it did upset Resident E, so he called his sister to set up a care plan conference for 2/14/25. The SSD didn't document his conversation in the chart, but he did file a grievance form and gave it to the Director of Nursing (DON) for follow up. During an interview on 2/13/25 at 9:32 A.M., the DON was unaware of the grievance form but would check in her office for it. On 2/13/25 at 10:00 A.M., the Administrator provided a grievance form, dated 2/8/25, which indicated the sister overheard staff arguing with her brother about whether his call light was on or not. The sister indicated it was (name of staff) and (name of staff). The form indicated the DON investigated the allegation and spoke with and educated the aides about customer service. During an interview on 2/11/25 at 2:12 P.M., CNA 25 and CNA 27 indicated Resident E used his call light. During an interview on 2/11/25 at 3:02 P.M., Licensed Practical Nurse (LPN) 19 indicated Resident E used to abuse his call light on the other unit, but he didn't anymore and he didn't call the nurse's station like he used to either. 38770 (continued on next page)

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F 0550 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	3. On 2/7/25 at 9:01 A.M., the Assistant Director of Nursing (ADON) was observed to administer medications to Resident F. Before she entered the room, the ADON indicated she was unsure if the resident would take the medications or not because she was like that. The ADON entered the room, provided the resident with her medications, then proceeded to walk toward the door. Before she exited, the ADON indicated (within earshot of the resident) she was surprised Resident F took her medications, and that went good, she can get feisty. The statement was voiced with attitude. On 2/13/25 at 11:55 A.M., the ADON indicated staff should treat all residents with the same respect and dignity they treated family. When working with residents, staff should not use foul language, talk about their own habits, or what they did outside of work. No inappropriate language, and should speak directly to the resident. She indicated no comments should be made to another person about that resident, and all residents should be treated with kindness and gentleness. On 2/13/25 at 12:19 P.M., the Administrator provided a current Resident Rights policy, dated 8/23/17, that indicated To promote the exercise of rights for each resident, including any who face barriers . in the exercise of these rights . rights include . exercise his or her rights . voice grievances and have the facility respond to those grievances . use a telephone in privacy . exercising rights means that residents have autonomy and choice, to the maximum extent possible, about how they wish to live their everyday lives and receive care, subject to the facility's rules, as long as those rules do not violate a regulatory requirement. This citation is related to Complaint IN00449788. 3.1-3(a) 3.1-3(t)

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F 0553 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Allow resident to participate in the development and implementation of his or her person-centered plan of care. 46416 Based on interview and record review, the facility failed to ensure timely care plan conferences with residents and/or their representatives for 3 of 7 residents reviewed for care plan conferences. Care plan conferences were not held quarterly for residents and/or their representatives to participate in planning of care. (Resident D, Resident 4, Resident 35) Findings include: 1. On 2/6/25 2:39 P.M., Resident D's clinical record was reviewed. Diagnoses included, but were not limited to, chronic obstructive pulmonary disease, diabetes mellitus type II, sepsis, UTI, flaccid bladder, and dementia with behaviors. The most recent Quarterly Minimum Data Set (MDS) assessment, dated 1/25/25, indicated Resident D's cognition was moderately impaired. The clinical record indicated Resident D had a care plan conference on 1/26/24, 4/26/24 and 10/4/24. During an interview on 2/11/25 at 2:27 P.M., the Social Services Director (SSD) indicated Resident D did not have any other care plan conferences in the last year. 2. On 2/11/25 at 9:26 A.M., Resident 4's clinical record was reviewed. Current diagnoses included, but was not limited to, dementia with behaviors. The most recent Quarterly MDS assessment, dated 10/4/24, indicated Resident 4 had severe cognitive impairment. The clinical record indicated Resident 4 had a care plan conference on 2/12/24, 6/14/24, and 9/27/24. During an interview on 2/11/25 at 2:27 P.M., the SSD indicated he was unable to contact Resident 4's guardian to set up a care plan conference. At that time, he indicated a care plan conference should have been held regardless and that Resident 4 had not had any other care plan conferences in the last year. 45933 3. On 2/7/25 at 9:57 A.M., Resident 35's clinical record was reviewed. Current diagnoses included, but was not limited to, stage 5 chronic kidney disease and hypertension. The most recent Quarterly Minimum Data Set (MDS) assessment, dated 12/17/24 indicated Resident 35 was cognitively intact. Resident 35 failed to receive a care plan conference between 7/23/24 and 12/17/24. (continued on next page)

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F 0553 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	During an interview on 2/11/25 at 2:25 P.M, the SSD indicated Resident 35 should have had a care plan conference between 7/23/24 and 12/17/24. At that time, he indicated care plan conferences should be completed quarterly. On 2/11/25 at 3:30 P.M., the Administrator provided a current Comprehensive Care Plan policy, revised 11/17/17 that indicated, .The resident and/or resident representative shall be invited to review the plan of care with the interdisciplinary team either in person, via telephone or video conference (if available) at least quarterly . 3.1-35(a)

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F 0578 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Honor the resident's right to request, refuse, and/or discontinue treatment, to participate in or refuse to participate in experimental research, and to formulate an advance directive. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 46882 Based on interview and record review, the facility failed to clarify a Resident's code status for 1 of 1 residents reviewed for advanced directives. A resident's current facesheet and Physician's Order did not match the signed Indiana Physician Orders for Scope of Treatment form. (Resident B) Finding includes: On [DATE] at 3:00 P.M., Resident B's clinical record was reviewed. Diagnoses included, but were not limited to heart failure, diabetes, dementia, anxiety, depression, and psychotic disorder. The most current Annual Minimum Data Set (MDS) assessment, dated [DATE], indicated Resident B had severe cognitive impairment, required set up or clean up (helper sets up or cleans up; resident completes activity) assistance for eating, was dependent (resident does none of the effort to complete the activity) on staff for toilet use and transfers, and required partial/moderate (helper does less than half the effort) assistance for bed mobility. Physician Orders included, but were not limited to the following: FULL CODE No directions specified for order, dated [DATE] The Care Plans indicated the following: Resident has a Full Code status, dated [DATE] The interventions included, but were not limited to the following: Assist resident and/or family with making changes to code status as desired. Inform all of my caregivers of Full Code Status Review wishes with resident/resident family quarterly and as needed On [DATE] at 03:07 P.M., the Indiana Physician Orders for Scope of Treatment (POST) form, dated [DATE], indicated Do Not Attempt Resuscitation (DNR). During an interview on [DATE] at 3:14 P.M., Registered Nurse (RN) 15 indicated to find out the resident's code status, she would see what was marked on the computer. She thought Resident B was a DNR. When she opened Resident B's record on the computer, it indicated he was a Full Code. When she looked at the POST form, it indicated DNR. When asked which one would she follow, she indicated that if Resident B coded, she would do a Full Code. RN 15 indicated the order and the POST form should match. (continued on next page)

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F 0578 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	On [DATE] at 3:30 P.M., the Administrator provided an Advance Directives policy, revised on [DATE], that indicated .8. If a resident or health care representative indicates an Advanced Directive regarding CPR [Cardiopulmonary Resuscitation] or Scope of Treatment (.Post form), the appropriate forms will be completed. 9. A written physician's order is required in response to the resident's Advanced Directive(s). Physician's orders shall be specific and address each Advanced Directive(s) . 3XXX,d+[DATE](l)(5)

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F 0609 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Timely report suspected abuse, neglect, or theft and report the results of the investigation to proper authorities. 46882 Based on interview and record review, the facility failed to ensure an incident report contained an explanation of the circumstances for an alleged incident. The incident report lacked details related to the actual incident reported involving a Certified Nurse Aide (CNA) and resident. (CNA 31, Resident B) Finding includes: An Indiana Department of Health (IDOH) incident report, dated 1/22/25, indicated a staff member reported CNA 31 was providing care that did not meet company standards for Resident B. On 2/10/25 at 3:00 P.M., Resident B's clinical record was reviewed. Diagnoses included, but were not limited to heart failure, diabetes, dementia, anxiety, depression, and psychotic disorder. The most current Annual Minimum Data Set (MDS) assessment, dated 1/13/25, indicated Resident B had severe cognitive impairment, required set up or clean up (helper sets up or cleans up; resident completes activity) assistance for eating, was dependent (resident does none of the effort to complete the activity) on staff for toilet use and transfers, and required partial/moderate (helper does less than half the effort) assistance for bed mobility. On 2/4/25 at 12:13 P.M., a Corrective Action Form completed by the Administrator, with date of incident recorded as 1/22/25 at 5:10 P.M., indicated CNA 29 came to my office, stated 'I think I just saw possible abuse of A hall resident.' She stated 'CNA 31 was turning resident , he grabbed her wrist so CNA 31 grabbed his testicles. She then was turning him d/t [due to] him being incontinent, using both hands, the resident grabbed both her wrists.' CNA 29 said 'It looked like she put her arm against his side of his neck.' I thanked her for making me aware as that is what suppose is [sic] to happen. I immediately left my office, went to A Hall, investigated the allegation. RN 15 and CNA 31 accompanied myself into the Resident's room. She stated 'I was washing his scrotum providing peri care from his incontinence. Then rolled him toward me to change him. He grabbed both my wrists. I never grabbed him by his scrotum not pressed my arm against his neck.' Full body assessment was completed. Scrotum was intact, no redness, abrasions noted. No swelling. Also looked at residents [sic] R [right] side of neck, compared with L [left] side of neck. Both =, no redness, no abrasions, no swelling. The CNA 31 demonstrated how she cleaned resident and turned him. Resident's bed (head) is against the wall, the side of his bed (left) is against the other wall. The CNA 31 demonstrated turning him over toward her to get him dry. Resident's BIMs [Brief Interview for Mental Status] is a 3. He is mostly nonverbal only saying words, i.e. [for example] good, yes, no. He does have a dx [diagnosis] dementia, resides on our memory care unit. Resolution: Investigation revealed no s/s [signs/symptoms] of abuse. Resident didn't express any pain. Psychosocial assessments were completed, no psychosocial issues founded. Res. [resident] family [primary contact] was notified per nurse consultant. I immediately suspended CNA 31 until the investigation was completed. (continued on next page)

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F 0609 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Time line: C/o [complaint of] was approx [approximately] 1/22/25 at 4:45 P.M., CNA 29 came to me at 5:10 P.M. I went immediately to the resident et [and] spoke with CNA 31, then walked her to timeclock to start the suspension. I made HR [Human Resources] aware, VP [Vice President] of Operations, she made [name of person] aware. We also changed the CNA 31 assignment to a different unit. No further issues noted. Signed by the Administrator and dated 1/23/25. During an interview on 2/13/25 at 11:11 A.M., VP of Operations indicated on reporting protocol-if we don't know what happened-on follow up will give the details of incident .if there was allegation thrown out from resident, would that allegation be in the initial report .maybe not will look for policy on how company wanted done. On 2/13/25 at 12:20 P.M., the Administrator provided an Abuse Prevention and Reporting-Indiana policy, revised on 10/28/22, indicated .The initial report to Department of Public Health shall include the following information, if known at the time of the report: .Type of abuse reported (physical, sexual, neglect, verbal or mental abuse, misappropriation of resident property), Date, time, location, and circumstances of the alleged incident . 3.1-28(c)

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F 0623 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Provide timely notification to the resident, and if applicable to the resident representative and ombudsman, before transfer or discharge, including appeal rights. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 45933 Based on interview and record review, the facility failed to ensure a notice of transfer or discharge was given to residents or resident representatives for 5 of 5 residents reviewed for hospitalization s and transfers. There was no documentation of a resident or representative receiving a notice of transfer or discharge at the time of hospitalization . (Resident D, Resident B, Resident 79, Resident 48, Resident 30) Findings include: 1. On 2/6/25 at 1:58 P.M., Resident 30's clinical record was reviewed and indicated they were admitted from the facility to the hospital on 11/8/24 and returned back to the facility from the hospital on 11/15/24. Resident 30's clinical record lacked a notice of transfer/discharge given to the resident or a representative at the time of transfer. During an interview on 2/13/25 at 11:19 A.M., the Administrator indicated they did not have any record of Resident 30 or Resident 30's representative receiving a notice of transfer or discharge on 11/8/24. At that time, she indicated the facility should fill out the state transfer forms. 46882 2. On 2/10/25 at 3:00 P.M., Resident B's clinical record was reviewed. Diagnoses included, but were not limited to heart failure, diabetes, dementia, anxiety, depression, and psychotic disorder. Resident B's clinical record indicated he was hospitalized on [DATE]. Resident B's clinical record lacked a hospital transfer notice. 3. On 2/10/25 at 10:16 A.M., Resident 48's clinical record was reviewed. Diagnoses included, but were not limited to anemia, arthritis, dementia, depression, and schizophrenia. Resident 48's clinical record indicated he was hospitalized on [DATE]. Resident 48's clinical record lacked a hospital transfer notice. 4. On 2/10/25 at 10:05 A.M., Resident 79's clinical record was reviewed. Diagnoses included, but were not limited to hypertension, fracture of hip, diabetes, dementia, anxiety, and depression. Resident 79's clinical record indicated she was hospitalized on [DATE]. Resident 79's clinical record lacked a hospital transfer notice. 46416 (continued on next page)

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F 0623 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	5. On 2/6/25 2:39 PM Resident D's clinical record was reviewed and indicated they were admitted from the facility to the hospital on 1/18/25 and returned back to the facility from the hospital on 1/22/24. The clinical record lacked documentation of a completed transfer/discharge notice given to the resident and representative at the time of transfer. The transfer assessment completed in the resident's assessments lacked information about the appeals process, the appeals form, and ombudsman contact information. During an interview on 2/11/25 at 2:37 P.M., Licensed Practical Nurse (LPN) 19 indicated the floor nurse was responsible for filling out the change in condition and transfer assessment forms in the electronic record only. There was nothing else in addition to those. During an interview on 2/13/25 at 9:25 A.M., the Social Services Director (SSD) indicated he sent the facility transfers and discharges monthly to the ombudsman's portal. He had the link he used in his email but at the time, his email was not working. He indicated he didn't have any documentation to verify sending them to the ombudsman. On 2/13/25 at 12:14 P.M., via email, the State Long-Term Care Ombudsman Program Deputy Director indicated, I only show receipt of the Oct and [DATE] monthly acute transfer reports. I don't see anything after [DATE] On 2/13/25 at 11:24 A.M., a current Transfer/Discharge Notice Policy was requested from the Administrator but was not received. 3.1-12(a)(6)(A)(i) 3.1-12(a)(6)(A)(iii) 3.1-12(a)(6)(A)(iv) 3.1-12(a)(9)

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F 0625 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Notify the resident or the resident's representative in writing how long the nursing home will hold the resident's bed in cases of transfer to a hospital or therapeutic leave. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 45933 Based on interview and record review, the facility failed to ensure a bed hold policy was given to residents or resident representatives for 5 of 5 residents reviewed for hospitalization s and transfers. There was no documentation of a resident or representative receiving a bed hold policy at the time of hospitalization . (Resident D, Resident B, Resident 79, Resident 48, Resident 30) Findings include: 1. On 2/6/25 at 1:58 P.M., Resident 30's clinical record was reviewed and indicated they were admitted from the facility to the hospital on 11/8/24 and returned back to the facility from the hospital on 11/15/24. Resident 30's records lacked a bed hold policy given to the resident or a representative at the time of the transfer. During an interview on 2/13/25 at 11:19 A.M., the Administrator indicated they did not have any record of Resident 30 or Resident 30's representative receiving a bed hold policy on 11/8/24. At that time, she indicated the facility should fill out the state bed hold form. 46882 2. On 2/10/25 at 3:00 P.M., Resident B's clinical record was reviewed. Diagnoses included, but were not limited to heart failure, diabetes, dementia, anxiety, depression, and psychotic disorder. Resident B's clinical record indicated he was hospitalized on [DATE]. Resident B's clinical record lacked a bed hold notice. 3. On 2/10/25 at 10:16 A.M., Resident 48's clinical record was reviewed. Diagnoses included, but were not limited to anemia, arthritis, dementia, depression, and schizophrenia. Resident 48's clinical record indicated he was hospitalized on [DATE]. Resident 48's clinical record lacked a bed hold notice. 4. On 2/10/25 at 10:05 A.M., Resident 79's clinical record was reviewed. Diagnoses included, but were not limited to hypertension, fracture of hip, diabetes, dementia, anxiety, and depression. Resident 79's clinical record indicated she was hospitalized on [DATE]. Resident 79's clinical record lacked a bed hold notice. 46416 (continued on next page)

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	155042	A. Building B. Wing	02/13/2025

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Aperion Care Vincennes	3801 Old Bruceville Road, Box 136 Vincennes, IN 47591

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F 0625 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	5. On 2/6/25 2:39 PM Resident D's clinical record was reviewed and indicated they were admitted from the facility to the hospital on 1/18/25 and returned back to the facility from the hospital on 1/22/24. The clinical record lacked documentation of a written bed hold notice and policy given to the resident and representative at the time of transfer. During an interview on 2/11/25 at 2:37 P.M., Licensed Practical Nurse (LPN) 19 indicated the floor nurse was responsible for filling out the change in condition and transfer assessment forms in the electronic record only. They no longer did the bed hold notice. On 2/12/25 at 11:04 A.M., a current Bed Hold Policy, revised 9/16/17, was provided by the Administrator and indicated, Purpose: To ensure that residents and/or resident representatives are notified of the facility bed hold policy and conditions for return to facility upon admission and at the time of a transfer from the facility . 3.1-12(a)(25) 3.1-12(a)(26)

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F 0656 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Develop and implement a complete care plan that meets all the resident's needs, with timetables and actions that can be measured. 45933 Based on observation, interview and record review, the facility failed to develop a care plan for 2 of 5 residents reviewed for Unnecessary Medications, and 1 of 1 residents reviewed for hospice services. A resident was administered an anticoagulant and an antiplatelet and did not have a care plan related to the medication. A resident received hospice services but lacked a care plan. (Resident D, Resident 79, Resident 67) Findings include: 1. On 2/10/25 at 11:53 A.M., Resident 67's clinical record was reviewed. Current diagnoses included, but was not limited to, non-traumatic brain dysfunction, anxiety, and depression. The most recent Minimum Data Set (MDS) assessment, dated 1/13/24 indicated Resident 67 is rarely/never understood, and a cognitive status could not be completed, and Resident 67 received hospice services. Current Physician's Orders included, but was not limited to, admit to hospice, dated 12/23/24. Resident 67's clinical record lacked a care plan related to hospice services. On 2/13/25 at 11:18 A.M., the [NAME] President of Operations indicated if a resident is on hospice, a hospice care plan should be initiated. 46882 2. On 2/10/25 at 10:05 A.M., Resident 79's clinical record was reviewed. Diagnoses included, but were not limited to hypertension, fracture of hip, diabetes, dementia, anxiety, and depression. The most current Quarterly Minimum Data Set (MDS) assessment, dated 1/10/25 indicated Resident 79 had severe cognitive impairment and was dependent (resident does none of the effort to complete the activity) on staff for eating, toilet use, bed mobility, and transfers. Resident 79 was on the following medications: antianxiety, antidepressant, and antiplatelet. Physician orders included, but were not limited to the following: Alarm when in bed, dated 12/19/2024 Alarm when up in chair, 12/19/2024 Resident 79's clinical record was not revised to include a care plan for bed alarm, and chair alarm after the order was added During an interview on 2/13/25 at 11:18 A.M., [NAME] President of Operations indicated there should be a care plan for alarm use. (continued on next page)

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F 0656 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	3. On 2/10/25 at 10:05 A.M., Resident 79's clinical record was reviewed. Diagnoses included, but were not limited to hypertension, fracture of hip, diabetes, dementia, anxiety, and depression. The most current Quarterly Minimum Data Set (MDS) assessment, dated 1/10/25 indicated Resident 79 had severe cognitive impairment and was dependent (resident does none of the effort to complete the activity) on staff for eating, toilet use, bed mobility, and transfers. Resident 79 was on the following medications: antianxiety, antidepressant, and antiplatelet. Physician orders included, but were not limited to the following: Aspirin Oral Tablet 325 MG (milligram) Give 1 tablet by mouth one time a day for Prophylaxis related to peripheral vascular disease, Start Date 12/24/2024 D/C (discontinued) Date 1/13/2025 Resident 79's clinical record lacked a care plan for antiplatelet medication. During an interview on 2/13/25 at 11:18 A.M., [NAME] President of Operations indicated there should be a care plan for antiplatelet use. 46416 4. On 2/6/25 2:39 PM Resident D's clinical record was reviewed. Diagnoses included, but were not limited to, chronic obstructive pulmonary disease, diabetes mellitus type II, deep vein thrombosis (DVT), sepsis, UTI, flaccid bladder, and dementia with behaviors. The most recent Quarterly Minimum Data Set (MDS) assessment, dated 1/25/25, indicated Resident D's cognition was moderately impaired, he received an anticoagulant, and was totally dependent on staff for toileting, transfers, and showers. Current Physician's Orders included, but were not limited to, the following: Xarelto 15 milligrams (MG) tablet, give one tablet by mouth two times a day for DVT, 1/23/2025 The clinical record lacked a care plan for an anticoagulant. During an interview on 2/10/25 2:26 admin indicated the MDS coordinator would be responsible for developing care plans and they would review them quarterly. During an interview on 2/13/25 at 11:18 A.M., the [NAME] President of Operations indicated a care plan would be expected within 72 hours for a resident who was put on an anticoagulant or antiplatelet medication. On 2/11/25 at 3:30 P.M., a current Comprehensive Care Plan Policy, revised 11/17/17, was provided by the Administrator and indicated A comprehensive care plan must be developed within 7 days after completion of the comprehensive assessment . 3.1-35(a) 3.1-35(c)(1)

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F 0657 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Develop the complete care plan within 7 days of the comprehensive assessment; and prepared, reviewed, and revised by a team of health professionals. 46416 Based on observation, interview, and record review, the facility failed to ensure comprehensive care plans were reviewed and revised by the interdisciplinary team (IDT) after each assessment, including both the comprehensive and quarterly review assessments. Care plans weren't revised for residents that were nothing by mouth (NPO), had a bed alarm, had a catheter removed, and a decline in activities of daily living (ADLs). (Resident C, Resident 73, Resident 79, Resident 4) Findings include: 1. On 2/10/25 at 10:27 A.M., Resident C's clinical record was reviewed. Diagnoses included, but were not limited to, stroke, hemiplegia on right dominant side, and dementia with mood disturbance. The most recent Annual Minimum Data Set (MDS) assessment, dated 1/8/25, indicated Resident C's cognition was moderately impaired and totally dependent on staff for toileting and transfers, and did not have an indwelling catheter. Current Physician's Orders were reviewed and lacked an order for an indwelling catheter. Resident C's care plans were reviewed and included, but were not limited to, the following: Resident has an indwelling catheter, last revised on 2/13/24 On 2/11/25 at 1:16 P.M., incontinence care was observed on Resident C. There was not an indwelling catheter observed. During an interview on 2/11/25 at 1:55 P.M., Certified Nurse Aide (CNA) 25 indicated Resident C did not have an indwelling catheter. 2. On 2/11/25 at 9:26 A.M., Resident 4's clinical record was reviewed. Diagnoses included, but was not limited to, dementia with behaviors. A recent Quarterly MDS assessment, dated 10/4/24, indicated resident 4's cognition was severely impaired, she was set up assistance by staff for eating and bed mobility, substantial/maximum assistance of staff (staff performs over half the effort) for transfers, and totally dependent on staff assistance for toileting and bathing. The most recent Quarterly MDS assessment, dated 1/14/25, indicated Resident 4's cognition was severely impaired, supervision from staff for eating (decline), substantial/maximum assistance of staff (staff performs over half the effort) for bed mobility (decline) and transfers, and totally dependent on staff assistance for toileting and bathing. (continued on next page)

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F 0657 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	During an interview on 2/11/25 at 2:18 P.M., CNA 27 indicated Resident 4 has had a recent decline in eating and mobility. She got sick and she was no longer able to stand and needed cuing to eat. She was getting some better, but then got sick again a few weeks ago and had been in bed more again. She indicated therapy was aware and they were going to work with her and staff to see if they could get her stronger. 3. On 2/4/25 at 11:12 A.M., Resident 73 was observed sitting in his room with a feeding tube. On 2/10/25 at 8:27 A.M., Resident 73's clinical record was reviewed. Diagnoses included, but not limited to, nontraumatic intracranial hemorrhage. The most recent Annual MDS assessment, dated 1/10/25, indicated Resident 73's cognition was severely impaired, he had a feeding tube, totally dependent on staff assistance for toileting and showering, and substantial/maximal assistance (staff performed half the effort) for transfers and bed mobility, and eating was non applicable. Current Physician's Orders included, but were not limited to, the following: Enteral Feed, Jevity 1.5 kcalorie/milliliter(ml), give 65 ml per hour via gastric tube every shift for nutrition and flush with 200 ml water every 4 hours, ordered 1/9/2024 Nothing By Mouth (NPO) diet, may have ice chips, ordered 1/9/2024 All current care plans were reviewed and lacked interventions related to the resident having an NPO diet (except ice chips). During an interview on 2/11/25 at 2:57 P.M., Licensed Practical Nurse (LPN) 19 indicated the resident was NPO. 46882 4. On 2/10/25 at 10:05 A.M., Resident 79's clinical record was reviewed. Diagnoses included, but were not limited to hypertension, fracture of hip, diabetes, dementia, anxiety, and depression. The most current Quarterly Minimum Data Set (MDS) assessment, dated 1/10/25 indicated Resident 79 had severe cognitive impairment and was dependent (resident does none of the effort to complete the activity) on staff for eating, toilet use, bed mobility, and transfers. Resident 79 was on the following medications: antianxiety, antidepressant, and antiplatelet. Physician Orders included, but were not limited to the following: Alarm when in bed, dated 12/19/2024 Alarm when up in chair, 12/19/2024 Resident 79's clinical record was not revised to include a care plan for bed alarm, and chair alarm after the order was added post fall. (continued on next page)

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F 0657 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	During an interview on 2/13/25 at 11:18 A.M., the [NAME] President of Operations indicated if a resident was NPO or had a bed alarm, she would expect the care plans to reflect that. Comprehensive care plans should be resident specific and be put in within 72 hours and revised quarterly, with change of condition, or with a new order. On 2/11/25 at 3:30 P.M., a current Comprehensive Care Plan Policy, dated 11/17/17, was provided by the Administrator and indicated . a comprehensive care plan must be reviewed and revised by the interdisciplinary team after each assessment, including both the comprehensive and quarterly review assessments. The CAAs [Care Area Assessments] provide a link between the MDS and care planning. The care plan should be revised on an ongoing basis to reflect changes in the resident and the care that the resident is receiving . 3.1-35(d)(2)(B)

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	155042	A. Building B. Wing	02/13/2025

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F 0686 Level of Harm - Actual harm Residents Affected - Few	Provide appropriate pressure ulcer care and prevent new ulcers from developing. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 38770 Based on observation, interview, and record review, the facility failed to ensure necessary treatment and services were provided to prevent and promote healing of facility acquired pressure injuries for 3 of 8 residents reviewed for pressure ulcers. Specific care plans were not developed, physician orders and other interventions not followed, and assessments were not completed thoroughly or accurately. This deficient practice resulted in facility acquired unstageable, Stage 3, and Stage 4 pressure ulcers. (Resident 20, Resident 7, Resident 25) Findings include: 1. On 2/5/25 at 11:05 A.M., Resident 20 was observed by the nurses' station sitting in a wheelchair. The resident was wearing slip on shoes on both feet. The left foot was wrapped with a gauze wrap and dated 2/4/25. On 2/6/25 at 2:31 P.M., Resident 20's clinical record was reviewed. Diagnosis included, but were not limited to, heart failure, diabetes mellitus, and dementia. The most recent Quarterly Minimum Data Set (MDS) assessment, dated 1/16/25, indicated no cognitive impairment and no behaviors. Resident 20 had two unstageable facility acquired pressure ulcers. (National Pressure Ulcer Advisory Panel defines an unstageable pressure ulcer as full thickness tissue loss in which the base of the ulcer is covered by slough (tan, brown or yellow) and /or eschar (tan, brown or black) in the wound bed.) Current physician orders included, but were not limited to: Treatment to Left Plantar Medial Heel: Cleanse with normal saline solution or Wound Wash, pat dry, apply calcium alginate to wound bed, cover with ABD pad, heel foam protector, and wrap with Kerlix (gauze wrap), secure with tape. Daily and as needed, dated 2/2/25. Treatment to Coccyx: Cleanse with normal saline solution, pat dry, apply collagen powder to open area, then insert calcium alginate, cover with Optifoam 4x4 dressing daily and as needed, dated 12/31/24. Float heels while resident in bed. Resident to wear pressure off loading boots every shift, dated 12/12/24. A current pressure ulcer care plan indicated an unstageable to the left medial heel as well as an unstageable to the coccyx, last revised 1/17/25. Interventions included, but were not limited to, follow physician orders for skin care and treatments, off load wound and float heels in bed every shift, treatments as ordered, and wound physician to manage wound care. Resident 20's clinical record lacked a separate care plan in place for the left medial heel pressure ulcer and the coccyx pressure ulcer. (continued on next page)

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	155042	A. Building B. Wing	02/13/2025

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F 0686 Level of Harm - Actual harm Residents Affected - Few	From November 2024 through February 2025, Resident 20's clinical record included the following assessments of pressure injuries: Coccyx 11/19/24 A wound nurse assessment indicated an unstageable coccyx pressure ulcer was identified that measured 1.5cm (centimeters) x 1cm x 0cm. An order was received 11/20/24 that indicated clean the coccyx with normal saline, apply calcium alginate, and cover with a foam dressing daily and as needed. The progress notes lacked documentation that the wound physician was notified of a coccyx pressure area and did not document on the area until 1/15/25. The wound physician note at that time indicated an unstageable coccyx pressure ulcer that measured 1cm x .5cm x .3cm. The coccyx wound lacked an assessment from 12/17/24 through 12/31/24. 12/31/24 The coccyx treatment order was changed to cleanse with normal saline, apply collagen powder to open area, insert calcium alginate, and cover with Optifoam 4x4 dressing. 1/7/25 A wound nurse assessment form indicated resident refused will assess tomorrow. The next wound nurse assessment was documented on 1/14/25. 1/22/25 A wound physician note indicated an unstageable coccyx pressure ulcer that measured 1cm x .5cm x .3cm. The wound physician indicated to continue the dressing treatment plan for calcium alginate and cover with foam border dressing daily. That order was not current and was not placed into Resident 20's clinical record. Resident 20's weekly skin assessments from 11/2024 through 2/2025 indicated the following assessment dates that lacked documentation of the coccyx: 11/21/24, 11/28/24, 12/5/24, 12/12/24, 12/14/24, 12/27/24, 1/3/25, 1/10/25, 1/31/25, and 2/7/25 Resident 20's Treatment Administration Record (TAR) from 11/2024 through 2/2025 indicated the following days a coccyx treatment was not completed and lacked an explanation: 11/20/24, 12/13/24, 12/19/24 On 2/11/25 at 10:40 A.M., the wound nurse was observed to change Resident 20's coccyx dressing. The area on the coccyx measured 2cm x 1cm x 0cm and was bright red on the inside with distinct edges. The area surrounding the wound was pink. When the old dressing was removed, red, pink, and brown drainage was observed on the inside of the dressing. The wound nurse cleansed the wound with normal saline, and applied collagen powder to the inside of the wound using a cotton tip applicator. A small square of calcium alginate was placed over the wound, and a large sacral dressing with a border was placed on top. The dressing was not dated or initialed. At that time, it was not the wound physician's recommendation to add collagen powder to the wound. Left Heel (continued on next page)

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	155042	A. Building B. Wing	02/13/2025

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F 0686 Level of Harm - Actual harm Residents Affected - Few	11/5/24 A wound nurse assessment indicated a facility acquired unstageable left heel pressure ulcer. The form indicated the area had been identified on 1/3/24. The wound currently measured 2cm x 1.5cm x unknown. Wound nurse assessments completed on the following dates identified the left heel pressure as unstageable: 11/11/24, 11/19/24, 11/26/24, 12/3/24, 12/10/24, 12/17/24, 12/24/24, 1/7/25, 1/14/25, 1/21/25, 1/29/25, 2/4/25 11/8/24 A wound physician note indicated a Stage 3 pressure ulcer (National Pressure Ulcer Advisory Panel defines Stage 3 Pressure Injury: Full-thickness skin loss Full-thickness loss of skin, in which adipose [fat] is visible in the ulcer and granulation tissue and epibole [rolled wound edges] are often present. Slough and/or eschar may be visible. The depth of tissue damage varies by anatomical location; areas of significant adiposity can develop deep wounds. Undermining and tunneling may occur. Fascia, muscle, tendon, ligament, cartilage and/or bone are not exposed. If slough or eschar obscures the extent of tissue loss this is an Unstageable Pressure Injury) to the left plantar medial heel that measured 3cm x 2cm x 0.1cm. The wound physician indicated to continue a treatment of calcium alginate, collagen powder, an ABD pad, and gauze roll. Wound physician assessments completed on the following dates identified the left heel pressure as Stage 3: 11/13/24, 11/20/24, 11/26/24, 12/4/24, 12/11/24, 12/18/24, 12/26/24, 1/8/25, 1/15/25, 1/22/25, 1/29/25, 2/5/25 11/16/24 Received new physician's order for the left heel to cleanse with normal saline, apply collagen powder and calcium alginate, and cover with Kerlix (gauze wrap). The order did not include an ABD pad as per the wound physician's recommendations. The ABD pad was not added to the order until 11/21/24 (5 days later). 12/12/24 Received new physician's order for the left heel to cleanse with normal saline, apply collagen powder and calcium alginate, then place an ABD pad, heel foam protector, and wrap with Kerlix daily and as needed. The most current wound physician recommendation did not include a heel foam protector. 1/29/25 The wound physician indicated to discontinue the collagen powder. The order was changed in the clinical record on 2/2/25 (4 days later). 2/5/25 The wound physician indicated to add collagen powder to the treatment plan. The new order was not placed in the resident's clinical record. Resident 20's weekly skin assessments from 11/2024 through 2/2025 indicated the following assessment dates that lacked documentation of the left heel: 11/21/24, 12/14/24, 12/19/24, 1/3/25, 1/10/25, 1/31/25 (continued on next page)

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	155042	A. Building B. Wing	02/13/2025

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F 0686 Level of Harm - Actual harm Residents Affected - Few	Resident 20's Treatment Administration Record (TAR) from 11/2024 through 2/2025 indicated the following days a left heel treatment was not completed with no explanation: 11/7/24, 11/8/24, 11/10/24, 11/11/24, 11/19/24, 11/20/24, 11/21/24, 11/22/24, 12/12/24, 12/13/24, 12/19/24, 2/2/25 On 2/11/25 at 10:40 A.M., the wound nurse was observed to change Resident 20's left heel dressing. The area on the left heel measured 2.5cm x 4cm and was pink on the inside. The surrounding area was pink and yellow, with dark red and black areas and non-distinct edges. When the old dressing was removed, brown drainage was observed on the inside of the dressing. The wound nurse cleansed the wound with normal saline, applied a single layer of calcium alginate, and placed an ABD pad over it. The area was then covered with a foam heel protector and the foot wrapped with a Kerlix. The dressing was not dated or initialed. At that time, collagen powder was not placed on the wound as recommended by the wound physician as it was not entered into the resident's current physician orders in the clinical record after the most recent recommendation. 2. On 2/6/25 at 2:43 P.M., Resident 7's clinical record was reviewed. Diagnosis included, but were not limited to, hemiplegia following a stroke effecting the right side, dementia, anxiety, and depression. The most recent Quarterly Minimum Data Set (MDS) assessment, dated 12/16/24, indicated severe cognitive impairment and no behaviors. Resident 7 required substantial to maximal assistance (staff assists with more than half the effort) and was totally dependent with bathing. Resident 7 had one facility acquired unstageable pressure ulcer. Current physician orders included, but were not limited to: Treatment for the left buttock: Cleanse area with normal saline, pat dry, apply [NAME]/Castor Oil twice a day and as needed, dated 12/31/24. A current pressure ulcer to the left buttock care plan, revised 2/4/25, was initiated 12/2/24 and included, but was not limited to, the following interventions: Treatments as ordered, dated 12/2/24. From November 2024 through February 2025, Resident 7's clinical record included the following assessments of a left buttock pressure injury: 11/17/24 A weekly skin assessment indicated a new skin concern. Resident had a newly identified Stage 2 pressure ulcer on the left buttock (National Pressure Ulcer Advisory Panel defines a Stage 2 pressure ulcer as a partial-thickness loss of skin with exposed dermis. The wound bed is viable, pink or red, moist, and may also present as an intact or ruptured serum-filled blister. Adipose [fat] is not visible and deeper tissues are not visible. Granulation tissue, slough and eschar are not present) and indicated a care plan was initiated. The care plan was initiated on 12/2/24 (15 days later). The assessment lacked measurements, color, or other condition or appearance of the wound. (continued on next page)

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	155042	A. Building B. Wing	02/13/2025

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Aperion Care Vincennes	3801 Old Bruceville Road, Box 136 Vincennes, IN 47591

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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 0686 Level of Harm - Actual harm Residents Affected - Few	11/26/24 A wound physician note indicated a Moisture Associated Skin Damage (MASD) area to the left buttock that measured 2cm x 1cm x .1cm. At that time, the wound physician indicated to add [NAME]/Castor Oil as a left buttock treatment. The order was not placed in the resident's clinical record until 12/5/24 (9 days later). 12/11/24 A wound physician note indicated an unstageable pressure injury to the left buttock that measured 4cm x .8cm x .1cm. At that time, the wound physician indicated to discontinue the [NAME]/Castor Oil and add Leptospermum Honey and a gauze island with border dressing daily. The new order was placed into the clinical record 12/12/24, but the [NAME]/Castor Oil was not discontinued until 12/31/24. On 12/19/24, the physician's order to apply leptospermum honey to the left buttock was discontinued. A new physician's order was received to cleanse the left buttock with normal saline, pat dry, apply Medi honey, then gauze Optifoam with border daily and as needed. The order received was not the current recommendation of the wound physician. 12/30/24 the wound physician indicated to change the Leptospermum Honey (which was not the current order in the clinical record, only their own most recent recommendation) to [NAME]/Castor Oil and discontinue the foam with border. The clinical record was updated with the new order the next day, 12/31/24. Wound nurse assessments completed on the following dates identified the left buttock pressure as Stage 2: 12/17/24, 12/24/24, 1/6/25, 1/13/25, 1/20/25, 1/27/25, 2/3/25 Wound physician assessments completed on the following dates identified the left buttock pressure as unstageable: 12/18/24, 12/26/24, 12/30/24, 1/8/15 1/15/25 A wound physician note indicated the unstageable pressure injury to the left buttock had resolved. The clinical record lacked clarification that the left buttock pressure area had been healed, and lacked documentation to the wound physician about the wound remaining. Resident 7's weekly skin assessments from 11/2024 through 2/2025 indicated the following assessment dates that lacked documentation of the left buttock: 11/20/24, 11/27/24, 12/4/24, 12/19/24, 1/2/25, 1/10/25, 1/15/25, 1/17/25, 1/18/25, 1/19/25, 1/24/25, 1/31/25, 2/5/25, 2/7/25 Resident 7's Treatment Administration Record (TAR) from 11/2024 through 2/2025 indicated the following days a left buttock treatment was not completed with no explanation: 12/13/24 evening shift, 12/18/24 evening shift, 12/19/24 evening shift, 12/21/24 evening shift, 2/3/25 evening shift (continued on next page)

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F 0686 Level of Harm - Actual harm Residents Affected - Few	On 2/10/25 at 10:33 A.M., the wound nurse was observed to enter Resident 7's room with supplies to change a dressing to her buttock. The resident indicated she was not feeling well, and pain was ten out of ten. The wound nurse indicated the resident had been given pain medication an hour prior, would not be doing the dressing change at that time, and left the room. 3. On 2/6/25 at 2:49 P.M., Resident 25's clinical record was reviewed. Diagnosis included, but were not limited to, paraplegia, anxiety, and depression. The most recent Quarterly Minimum Data Set (MDS) Assessment, dated 1/8/25, indicated no cognitive impairment and no behaviors. Resident 25 was dependent on staff with toileting, bed mobility, transfers, and bathing. The resident had one facility acquired Stage 4 pressure ulcer. (National Pressure Ulcer Advisory Panel defines Stage 4 Pressure Injury as full-thickness skin and tissue loss. Full-thickness skin and tissue loss with exposed or directly palpable fascia, muscle, tendon, ligament, cartilage or bone in the ulcer. Slough and/or eschar may be visible. Epibole [rolled edges], undermining and/or tunneling often occur. Depth varies by anatomical location. If slough or eschar obscures the extent of tissue loss this is an Unstageable Pressure Injury). Current physician orders included, but were not limited to: Treatment to left/right buttocks: Cleanse with soap and water, pat dry, then apply barrier cream twice a day and as needed every day and evening for wound, dated 12/20/24. [NAME]/Castor Oil ointment, apply to left buttocks every day and evening shift for wound care. Cleanse with soap and water and pat dry before applying. Twice a day and as needed, dated 12/5/24. A current pressure ulcer care plan included both the left buttock and right trochanter (hip), revised 2/4/25 and initiated 4/23/24. Interventions included, but were not limited to, wound physician follows wound care, weekly treatment documentation to include measurement of each area of skin breakdown's width, length, depth, type of tissue and exudate (drainage). From November 2024 through February 2025, Resident 7's clinical record included the following assessments of a left buttock pressure injury: 11/1/24 A wound nurse assessment indicated a facility acquired left buttock Deep Tissue Pressure Injury (DTI), identified on 4/23/24. The wound measured 5.5cm x 4.5cm x 0cm. 11/8/24 A wound physician assessment indicated a Stage 4 left buttock pressure ulcer that measured 6cm x 3.6cm x .1cm. At that time, the wound physician indicated to continue [NAME]/Castor Oil twice a day. At that time, the current order was for a daily treatment. The order wasn't changed to twice a day until 11/21/24 (13 days later). 2/5/25 A wound physician assessment indicated a Stage 4 left buttock pressure ulcer that measured 4.2cm x 2.6cm x .1cm. At that time, the wound physician indicated to discontinue [NAME]/Castor Oil and add Leptospermum Honey with a gauze island with border once a day. The new order was not placed into the resident's clinical record. Resident 25's weekly skin assessments from 11/2024 through 2/2025 indicated the following assessment dates that lacked documentation of the left buttock: (continued on next page)

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F 0686 Level of Harm - Actual harm Residents Affected - Few	11/25/24, 12/9/24, 12/31/24, 1/7/25, 1/14/25, 1/20/25, 2/3/25 Resident 25's TAR indicated the following dates from November 2024 through February 2025 the treatment for the left buttock was not completed: 11/4/24 evening shift, 11/11/24 evening shift, 11/19/24 day shift, 11/28/24 day shift, 12/3/24 evening shift, 12/13/24 evening shift, 12/18/24 evening shift, 12/19/24 evening shift, 12/21/24 evening shift On 2/10/25 at 10:40 A.M., the wound nurse was observed to prepare to change Resident 25's left buttock dressing. Upon observing him from the hallway, Resident 25 was sitting in a wheelchair, out of the bed. The wound nurse sighed and indicated that since the staff had already assisted the resident to get up, it would be too much trouble to get him back to bed, and she would be unable to do the dressing at that time. On 2/13/24 at 10:12 A.M., the wound nurse indicated she made weekly rounds with the wound physician. If she was not in the building, the floor nurse would usually do it. She indicated the orders in the resident's clinical record should be the most recent orders from the wound physician, as those orders were placed into the clinical record either the day of the assessment or the following day. She indicated the wound physician will sometimes give a verbal order or change the dressing in the middle of a dressing change, but that order should be what was current in the clinical records. She indicated she was unsure why her assessments indicated different staging and measurements than the wound physician and could be because they differ in how they measure wounds. She further indicated weekly skin assessments were entered by the floor nurses, should include something to address current wounds, and all the nurses had been inserviced how to fill them out. She indicated the floor nurses were also responsible for daily treatments and would expect them to be carried out as ordered. She indicated although she was not the one that currently entered care plans, there should have been a separate care plan for each wound unless it required the same interventions. On 2/12/25 at 11:26 A.M., the Administrator provided a current Wound Nurse description, dated 3/23/17, that indicated The Wound Nurse is responsible for providing primary skin care to residents under the medical direction and supervisor of the residents' attending physician, the Director of Nursing, or the Medical Director of the facility, with an emphasis on treatment and therapy of skin disorders . Examine the resident and his/her records and charts, and discriminate between normal and abnormal findings, in order to recognize when to refer the resident to a physician for evaluation, supervision, or directions . Provide assessment and diagnostic services to residents. Perform an assessment evaluation using techniques including observation, inspection, and palpation . Implement and maintain established policies and procedures relative to skin care treatments. (continued on next page)

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F 0686 Level of Harm - Actual harm Residents Affected - Few	On 2/11/25 at 3:30 P.M., the Administrator provided a current Skin Condition Assessment and Monitoring Pressure and Non-Pressure policy, dated 6/8/18, that indicated Pressure and other ulcers . will be assessed and measured at least weekly by licensed nurse and documented in the resident's clinical record . residents identified will have a weekly skin assessment by a licensed nurse . at the earliest sign of a pressure injury or other skin problem, the resident, legal representative, and attending physician will be notified. The initial observation of the ulcer or skin breakdown will also be described in the nursing progress notes . dressings which are applied to pressure ulcers, skin tears, wounds, lesions, or incisions shall include the date of the licensed nurse who performed the procedure . the licensed nurse is responsible for notifying the attending physician, Director of Nursing and legal representative of any suspected wound infection . a licensed nurse shall observe condition of wound incision daily, or with dressing changes as ordered. Observations such as drainage, dehiscence, redness, swelling, or pain will be documented in the nurse's notes. 3.1-40(a)

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F 0690 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide appropriate care for residents who are continent or incontinent of bowel/bladder, appropriate catheter care, and appropriate care to prevent urinary tract infections. 46416 Based on observation, interview, and record review, the facility failed to ensure residents with indwelling urinary catheters received appropriate orders and services to prevent urinary tract infections (UTI) for 2 of 3 residents reviewed for catheter care. A resident's urinary catheter bag was not placed lower then his bladder and a resident with a urinary catheter did not have an order. (Resident D, Resident 48) Findings include: 1. On 2/5/25 at 11:01 A.M., Resident D was laying with his head of his bed and foot of the bed elevated. The resident's indwelling catheter bag was observed under the resident's left leg and there was yellow liquid in it and in the tubing. On 2/6/25 2:39 PM Resident D's clinical record was reviewed. Diagnoses included, but were not limited to, chronic obstructive pulmonary disease, diabetes mellitus type II, sepsis, UTI, flaccid bladder, and dementia with behaviors. The most recent Quarterly Minimum Data Set (MDS) assessment, dated 1/25/25, indicated Resident D's cognition was moderately impaired, had a catheter, and was totally dependent on staff for toileting, transfers, and showers. Current Physician's Orders included, but were not limited to, the following: Foley Catheter, size 18 french/30 milliliter balloon, to gravity drain every shift, ordered 1/9/2025 A current Indwelling Foley Catheter Care Plan, last revised 7/3/24, included, but was not limited to the following intervention: Position catheter bag and tubing below the level of the bladder and away from entrance room door, revised 7/3/24 During an interview on 2/11/25 at 2:09 P.M., Certified Nurse Aide (CNA) 25 indicated the nurses do catheter care, but the CNAs should drain the bag every shift. The bag should be covered and hung on the side of the bed. If the resident was in bed, the bag should definitely not be on his leg. 46882 2. On 2/10/25 at 10:48 A.M., Resident 48 was observed sitting up in a recliner in his room with his eyes closed, Foley catheter hooked to rollator walker in front of him, and television (TV) was on. On Enhanced Barrier Precautions (EBP) for catheter. There was a sign posted outside his room on the wall. (continued on next page)

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F 0690 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	On 2/11/25 at 10:47 A.M., Resident 48 was observed up in a recliner, lying back, eyes closed, Foley catheter draining yellow urine and hooked to rollator walker, occasional cough, and EBP in place. On 2/11/25 at 1:22 P.M., Resident 48 was observed sitting up in recliner in his room, Foley catheter draining yellow urine, hooked to rollator in front of resident, and TV on. On 2/10/25 at 10:16 A.M., Resident 48's clinical record was reviewed. Diagnoses included, but were not limited to anemia, arthritis, dementia, depression, and schizophrenia. The most current Quarterly Minimum Data Set (MDS) assessment, dated 1/26/25, indicated Resident 48 had severe cognitive impairment, was occasionally incontinent of urine, and did not have a catheter. Resident 48's clinical record lacked a Physician's Order and care plan for a Foley catheter. During an interview on 2/10/25 at 11:03 A.M. Registered Nurse (RN) 17 indicated Resident 48 was hospitalized for pneumonia and urinary tract infection (UTI). Foley catheter was inserted while he was in the hospital. The hospital staff tried to remove it before he returned but were unable to so the put it back in. There should be an order for the Foley catheter. During an interview on 2/13/25 at 11:18 A.M., [NAME] President of Operations indicated there should be a care plan for Foley catheter use. On 2/11/25 at 3:30 P.M., a current Urinary Catheter Care Policy, revised 2/14/19, was provided by the Administrator and indicated . Catheters shall be positioned to maintain a downhill flow of urine to prevent a back flow of urine into the bladder or tubing, during transfer, ambulation and body positioning . On 2/13/25 at 3:00 P.M., the Director of Nursing (DON) indicated they didn't have a policy for a catheter order, but it was their policy that anyone who had a catheter should have an order for it. 3.1-41(a)(1) 3.1-41(a)(2)

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F 0744 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Provide the appropriate treatment and services to a resident who displays or is diagnosed with dementia. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 46882 Based on observation, interview and record review, the facility failed to ensure a resident who displayed or was diagnosed with dementia, received the appropriate treatment and services to attain or maintain his highest practicable physical, mental, and psychosocial well-being for 1 of 5 residents reviewed on the dementia unit. A Certified Nurse Aide (CNA) failed to provide appropriate Activities of Daily Living (ADL) care for a resident on the dementia unit along with other concerns on the hall with 15 men. (Resident B, men's hall) Finding includes: 1. On 2/5/25 at 11:33 A.M., Resident B was observed in a wheelchair in activities. At that time, his hair was not combed. On 2/10/25 at 10:47 A.M., Resident B was observed sitting up in a wheelchair in the common area next to table, eyes closed. On 2/10/25 at 11:15 A.M. Resident B was observed awake sitting in a wheelchair in common area with a word search paper in front of him at table, making marks on paper. On 2/11/25 at 10:45 A.M., Resident B was observed sitting up in a wheelchair in common area next to table watching TV. On 2/11/25 at 1:18 P.M., Resident B sitting up in wheelchair next to dining room table, holding his lunch tray, ate all of lunch, propelled self away from table. An Indiana Department of Health (IDOH) incident report, dated 1/22/25, indicated a staff member reported CNA 31 was providing care that did not meet company standards for Resident B. On 2/10/25 at 3:00 P.M., Resident B's clinical record was reviewed. Diagnoses included, but were not limited to heart failure, diabetes, dementia, anxiety, depression, and psychotic disorder. The most current Annual Minimum Data Set (MDS) assessment, dated 1/13/25, indicated Resident B had severe cognitive impairment, required set up or clean up (helper sets up or cleans up; resident completes activity) assistance for eating, was dependent (resident does none of the effort to complete the activity) on staff for toilet use and transfers, and required partial/moderate (helper does less than half the effort) assistance for bed mobility. 2. During an interview on 2/10/25 at 11:13 A.M., CNA 35 indicated she had worked with CNA 31 on the dementia unit. She indicated CNA 31 came off gruff, her voice was loud, she would go into a resident's room and just start care without telling the residents what she was going to do. CNA 35 indicated CNA 31 would deny the male residents refills of coffee when they asked for it. She indicated the atmosphere in the A hall that consisted of 15 men was better since CNA 31 had been working on a different hall. (continued on next page)

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F 0744 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	During an interview on 2/10/25 at 3:18 P.M., Registered Nurse (RN) 15 indicated she had been here almost [AGE] years and worked the 2 P.M.-10 P.M. shift. She indicated on 1/22/25 she was not aware of the incident until the Administrator came to the unit and asked her to go to Resident B's room. She indicated CNA did sit down by her while she was charting but did not tell her anything about the situation. RN 15 indicated the unit was calmer since CNA 31 was not working on it. She indicated male residents and staff would complain how rough CNA 31 was and she intimidated the residents. Residents would ask if CNA 31 was working. They were glad when she wasn't on the unit. RN 15 indicted CNA 31 would disappear for long periods of time-go outside or go to the bathroom for 30 minutes or more. RN 15 indicated about 3-4 weeks ago the Wound Nurse reported to her that CNA 31 was lying on a resident's bed talking on her phone. When RN 15 went to the resident's room CNA 31 was lying on the bed talking on her phone and the resident was in the room in a wheelchair. RN 15 indicated she reported the incident to the ADON but nothing was done about it. On 2/11/25 at 9:15 A.M., CNA 31's Employee File was reviewed and indicated CNA 31 had the following dementia training: 1 hour (hr) on 3/28/24, 1 hr on 3/24/24, 0.5 hrs on 3/23/24, 1 hr on 3/23/24, 0.5 hr on 3/23/24, and 0.25 hr on 3/13/24. She had Alzheimer's disease training of 1 hr on 3/15/24 and 1 hr on 3/10/24, Residents Rights on 2/15/24, Abuse on 2/15/24. On 2/11/25 at 3:41 P.M., the [NAME] President of Operations provided an undated Activities of Daily Living policy which indicated .Give a clear message: .Respect space .Do not rush .Special Instructions: Ask yes/no questions, Use one step commands, Offer choices one at a time .Do one thing at a time and be ready to follow the resident's preference . On 2/13/25 at 11:26 A.M., the Administrator indicated she would expect the residents on the Dementia unit to be treated the same way as stated in the policy during ADLs. This citation relates to complaint IN00452319. 3.1-37(a)

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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** 46416 Based on interview and record review, the facility failed to ensure pharmaceutical services (including procedures that assure the accurate acquiring, receiving, dispensing, and administering of all drugs and biologicals) met the needs of each resident for 1 of 1 residents reviewed for antibiotic use. A resident's antibiotics (taken for multiple infections) were not continued in a timely manner after discharge from the hospital. (Resident D) Finding includes: On 2/6/25 2:39 PM Resident D's clinical record was reviewed. Diagnoses included, but were not limited to, chronic obstructive pulmonary disease (COPD), diabetes mellitus type II, deep vein thrombosis (DVT), sepsis, urinary tract infection (UTI), flaccid bladder, and dementia with behaviors. The most recent Quarterly Minimum Data Set (MDS) assessment, dated 1/25/25, indicated Resident D's cognition was moderately impaired and he was totally dependent on staff for toileting, transfers, and showers. An After Visit Summary, dated 1/22/25, indicated Resident D was admitted to the hospital on 1/18/25 and discharged to the facility on [DATE] at 12:55 P.M. Diagnoses during his stay included, but were not limited to, sepsis, catheter-associated urinary tract infection, Respiratory Syncytial Virus (RSV), and COPD with respiratory failure with hypoxia (low oxygen level). The medication list to continue when discharged included, but was not limited to, the following: cefdinir (antibiotic) 300 milligram (mg) capsule, take one capsule by mouth every 12 hours for one dose (to finish course) at bedtime tonight (1/22/25) doxycycline (antibiotic) 100 mg capsule, take one capsule by mouth every 12 hours for ten total doses starting tonight (1/22/25) A pharmacy review, dated 1/23/25, indicated the doxycycline was not transcribed from the discharge orders and the cefdinir dose was not given. An undated handwritten note at the bottom of the letter indicated, Phoned doctor: Awaiting response. A nurse's note, dated 1/23/25 at 6:52 P.M., indicated the Medical Doctor (MD) was notified that resident missed 48 hours of his cefdinir and doxycycline related to technical error. New orders received to continue doxycycline 100 mg twice day for four days for diagnosis of RSV. The Medication Administration Record (MAR) for January 2025 was reviewed and indicated the following: cefdinir 300 mg capsule by mouth two times a day for infection until 1/25/25 4:00 P.M. was ordered with a start date of 1/24/25 at 8:00 A.M. The medication was given for three doses (1/25/25 at 8:00 A.M., 1/25/25 at 4:00 P.M., 1/26/25 at 8:00 A.M.) (continued on next page)

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F 0755 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	doxycycline 100mg tablet by mouth two times a day for RSV for five days until finished was ordered with a start date of 1/26/25 8:00 P.M. The medication was given for 10 doses starting at 8:00 P.M. on 1/26/25. During an interview on 2/12/25 at 11:26 A.M., the Administrator indicated it was the receiving nurse's responsibility to review and put in medication orders when a resident was readmitted from the hospital and she did. The cefdinir came in, but the doxycycline did not come from the pharmacy for an unknown reason. The nurse notified the MD about the missed doses and when the doxycycline came in, the resident got all the doses. During an interview on 2/12/25 at 1:38 P.M., the Infection Preventionist indicated they do follow an antibiotic stewardship program. The prescriber was responsible for making sure the indication, dose, and duration were correct and the pharmacy would also review it. If the medication was in the emergency drug kit (EDK) they could give it right away, otherwise they would have to wait for the pharmacy which didn't usually take long. They discuss and review antibiotic use in the Quality Assessment and Assurance (QAA) meetings. On 12/13/25 at 12:22 P.M., a current Pharmacy Policy, revised August 2020, was provided by the Administrator and indicated . providing routine and timely pharmacy service as contracted, as well as emergency pharmacy service 24 hours per day, seven days per week. New medication orders are available for administration on the next routine delivery, unless otherwise requested by facility staff. Medications will be delivered by the primary pharmacy or back-up pharmacy or are available from the emergency medication kit . 3.1-25(a)

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F 0759 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure medication error rates are not 5 percent or greater. 38770 Based on observation, record review, and interview, the facility failed to ensure it was free of a medication error rate of greater than 5 percent for 2 of 3 residents (Residents 6, Resident D) observed during medication pass. Two medication errors were observed during 31 opportunities for error in medication administration. This resulted in a medication error rate of 6.45 percent. Findings include: 1. On 2/7/25 at 9:40 A.M., the ADON was observed to administer 16 units of Lyumjev (insulin lispro) via an insulin pen to Resident D. The ADON did not prime the pen prior to clicking it to the number of units. At that time, she questioned whether the pen needed to primed, and indicated she did not prime insulin pens, and only primed needles when drawing insulin from a vial. 2. On 2/7/25 at 9:25 A.M., the ADON was observed to prepare an insulin administration for Resident 6. At that time, the ADON indicated she could not find the resident's insulin, and would request it from the pharmacy to be delivered that afternoon. On 2/7/25 at 2:04 P.M., the ADON indicated Resident 6's insulin had been found in another medication cart that morning, but that Resident 6 missed the 8:00 A.M. dose. On 2/13/25 at 10:57 A.M., Resident 6's clinical record was reviewed. A current order for Novolog insulin indicated to administer based on the following sliding scale: 150 - 200 = 2 units; 201 - 250 = 4 units; 251 - 300 = 6 units; 301 - 350 = 8 units; 351 - 400 = 10 units Notify MD (Medical Doctor) and or NP (Nurse Practitioner) of blood sugar greater than 400, subcutaneously three times a day Resident 6's Medication Administration Record (MAR) indicated a blood sugar of 223 on 2/7/25 at 8:00 A.M. Resident 6 should have received 4 units of insulin at that time. On 2/13/25 at 10:01 A.M., the Director of Nursing (DON) indicated it was the policy of the facility to prime all insulin pens prior to use. 3.1-48(c)(1)

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	02/13/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Aperion Care Vincennes	3801 Old Bruceville Road, Box 136 Vincennes, IN 47591

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F 0760 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure that residents are free from significant medication errors. 38770 Based on observation, interview, and record review, the facility failed to ensure prevention of a significant medication error for 1 of 3 residents observed for medication administration. A dose of insulin was not given resulting in an increase of blood sugar. (Resident 6) Finding includes: On 2/7/25 at 9:25 A.M., the ADON was observed to prepare an insulin administration for Resident 6. At that time, the ADON indicated she could not find the resident's insulin in the medication cart or the medication storage room, and would request it from the pharmacy to be delivered that afternoon. On 2/7/25 at 2:04 P.M., the ADON indicated Resident 6's insulin had been found in another medication cart that morning, but that Resident 6 missed the 8:00 A.M. dose. On 2/13/25 at 10:57 A.M., Resident 6's clinical record was reviewed. A current order for Novolog insulin indicated to administer based on the following sliding scale: 150 - 200 = 2 units; 201 - 250 = 4 units; 251 - 300 = 6 units; 301 - 350 = 8 units; 351 - 400 = 10 units Notify MD (Medical Doctor) and or NP (Nurse Practitioner) of blood sugar greater than 400, subcutaneously three times a day Resident 6's Medication Administration Record (MAR) indicated a blood sugar of 223 on 2/7/25 at 8:00 A.M. Resident 6 should have received 4 units of insulin at that time. At 12:00 P.M., Resident 6's blood sugar was 362 (139 higher than the reading at 8:00 A.M.), requiring 10 units of insulin. The clinical record lacked notification to the physician related to the missed dose of insulin on 2/7/25. On 2/13/25 at 11:11 A.M., the [NAME] President (VP) of Operations indicated the ADON had notified her of Resident 6's missed dose of insulin on the day it happened and was advised to call the physician. She indicated when there was a missed insulin dose, the physician sometimes gave an order for a different type of insulin, or the facility could get it immediately from the pharmacy. At that time, documentation to the physician and their response to the call was requested and not provided. On 2/13/25 at 11:55 A.M., a current nondated Medication Errors and Drug Reactions policy was provided and indicated Notify the attending physician or Medical Director if the attending physician is not available . A detailed account of the incident must be recorded in the resident's medical record (continued on next page)

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	155042	A. Building B. Wing	02/13/2025

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F 0760 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	3.1-48(c)(2)

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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 0761 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Ensure drugs and biologicals used in the facility are labeled in accordance with currently accepted professional principles; and all drugs and biologicals must be stored in locked compartments, separately locked, compartments for controlled drugs. 38770 Based on observation, interview, and record review, the facility failed to follow facility policy by ensuring safe and secure storage of medications for 5 residents during 2 random observations of the medication carts. Medications had been pre-prepared and held in medication cups in the medication cart prior to administration. (Resident B, Resident G, Resident 76, Resident 34, Resident 19) Findings include: 1. On 2/4/25 at 10:00 A.M., the medication cart on B Hall was observed. Qualified Medication Aide (QMA) 5 opened the top drawer and four medication cups were observed with pills in them. The names written on the cups were as follows: Resident G (1 pill) Resident 76 (1 pill) Resident 34 (2 pills) Resident B (1 pill) At that time, QMA 5 indicated the medication cups had been prepared for the 11:00 A.M. medication pass and she was aware they were not supposed to be in the cart pre-prepared. 2. On 2/4/25 at 10:15 A.M., medication cart on D Hall was observed. Licensed Practical Nurse (LPN) 7 opened the top drawer and a medication cup was observed with eight pills in it. Resident 19's name was written on the cup. At that time, LPN 7 indicated they were Resident 19's 8:00 A.M. morning medications and he had refused them. On 2/13/25 at 10:01 A.M., the Director of Nursing (DON) indicated she was unaware what the facility's policy was related to pre-preparing medications, but if the resident refused medications, they could be locked in the cart while the staff member got another nurse to attempt to administer the medications. On 2/7/25 at 2:20 P.M., the [NAME] President (VP) of Operations provided a nondated Medication Administration General Guidelines policy that indicated . medications are administered at the time they are prepared. Medications are not pre-poured either in advance of the med pass or for more than one resident at a time 3.1-25(b)(5)

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	155042	A. Building B. Wing	02/13/2025

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F 0801 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	Employ sufficient staff with the appropriate competencies and skills sets to carry out the functions of the food and nutrition service, including a qualified dietician. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 46416 Based on interview and record review, the facility failed to employ sufficient staff with the appropriate competencies and skills set to carry out the functions of the food and nutrition service for 1 of 1 kitchens observed. The Dietary Manager was not certified. (Dietary Manager) Finding includes: On [DATE] at 9:51 A.M., the Dietary Manager was asked to provide her certification certificate. At that time, she indicated she was not certified yet, but she was working on it. She indicated she started working at the facility in August of 2024 and her previous certification had expired. During an interview on [DATE] at 10:49 A.M., the Administrator indicated they knew the Dietary Manager needed to take her test again because she failed the first time, but the new test date was unknown. At that time, the Administrator indicated the Dietary Manager was on a 30 day Performance Improvement Plan (PIP). On [DATE] at 11:33 A.M., the Administrator provided the PIP on the dietary manager, dated [DATE] and [DATE], which included, but were not limited to, the following issues: Dietary Manager needed to complete her training. Training had not been completed. It had been addressed multiple times. Training must be completed within 30 days. During an interview on [DATE] at 1:50 P.M., the Administrator indicated it would be policy to follow regulations and to have certified dietary manager. This citation relates to Complaints IN00449788. 3XXX,d+[DATE](a)

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	155042	A. Building B. Wing	02/13/2025

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F 0803 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Ensure menus must meet the nutritional needs of residents, be prepared in advance, be followed, be updated, be reviewed by dietician, and meet the needs of the resident. 46416 Based on interview and record review, the facility failed to ensure menus were being followed by dietary staff for 1 of 1 kitchens reviewed. (Kitchen) Finding includes: During an interview on 2/10/25 at 10:49 A.M., the Administrator indicated the Dietary Manager was on a 30 day Performance Improvement Plan (PIP). The Administrator indicated when she took over 12/9/24, it took her two days to see and know the kitchen had major concerns. The Dietary Manager was already on a 30 day PIP for not following menus at that time like they should have been but the menus have been followed since the current Administrator took over. At that time, the Administrator indicated no one held the staff accountable for what they did wrong. The turnover in Administration probably had some to do with it because the staff were on their own. They continued the PIP for another 30 days and the Dietary Manager was told she would not be able to maintain the role unless things were changed. The next PIP review date is 2/14/25. The Administrator indicated majority of the resident grievances were about dietary services. On 2/10/25 at 11:33 A.M., the Administrator provided the PIP on the dietary manager, dated 12/2/24 and 1/15/25, which included, but were not limited to, the following issues: Dietary Manager needed to make sure staff was following menus and order the correct items for the menu. Dietary Manager needed to complete inventory before placing orders to ensure she had what she needed for the upcoming menus. The staff can't cook it if they don't have it. Menus must be followed at every meal. Dietary Manager to monitor, educate cooks, and must have inventory completed prior to each order. During an interview on 2/10/25 at 2:56 P.M., the Administrator indicated it would be policy to follow regulations and to follow the assigned menus. This citation relates to Complaint IN00449788. 3.1-20(i)

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	155042	A. Building B. Wing	02/13/2025

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F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Provide and implement an infection prevention and control program. 46416 Based on observation, interview, and record review, the facility failed to provide a safe and sanitary environment to help prevent the development and transmission of communicable diseases and infections for 4 of 6 residents observed for infection control. Staff did not clean the shared glucometer prior to use, staff was not using proper personal protective equipment (PPE) or signage, and hands were not sanitized between glove use. (Resident C, Resident D, Resident G, Resident H) Findings include: 1. On 2/10/25 at 10:27 A.M., Resident C's clinical record was reviewed. Diagnoses included, but were not limited to, stroke, hemiplegia on right dominant side, and dementia with mood disturbance. The most recent Annual Minimum Data Set (MDS) assessment, dated 1/8/25, indicated Resident C's cognition was moderately impaired and totally dependent on staff for toileting and transfers. On 2/11/25 at 1:16 P.M., incontinence care was observed on Resident C performed by Certified Nurse Aide (CNA) 25 and CNA 27. Staff came into the room wearing a gown and mask. CNA 27 put on gloves lowered the bed, grabbed the bed to move it away from the wall, and moved the soiled sheet off the resident. CNA 25 put on gloves, opened the bathroom door, turned on the faucet, wet a stack of tattered wash cloths, turned off the faucet, and put the wash cloths on the clean towel that covered the bedside table. CNA 27 rolled the soiled incontinence pad down between the resident's legs. A large amount of bowel movement was visible on the resident's right and left groin area. CNA 27 took off her gloves and put new gloves on without sanitizing hands. Both CNAs took off the resident's gown and laid a clean blanket across the resident's chest and rolled the resident to her right side while CNA 27 wiped a large amount of bowel movement from the buttocks, folded the wash cloth, and wiped again. CNA 27 took off her gloves and went into the bathroom to wet more wash cloths. CNA 27 continued to wipe the resident's buttocks until no more bowel movement was visible. CNA 25 noticed the clean incontinence pad they were going to put on the resident was not the right size so she took off her gown and went out of the room to get a different one. CNA 27 continued rolling the soiled sheets, wash cloths, and chucks under the resident's right side. CNA 27 took off her gloves and put on new ones without sanitizing her hands. CNA 25 returned in a new gown with a clean brief. CNA 27 took the brief and placed it along with a blanket to cover the bed under the soiled linens rolled under the resident's right side. CNA 25 put on gloves. Both CNAs helped roll the resident onto her left side. CNA 25 rolled the soiled incontinence pad and soiled linens out from under the resident and put them into a trash bag and then pulled out the clean blanket and incontinence pad. CNA 25 then wiped bowel movement off of the resident's right leg. CNA 25 took her gloves off and went to wet more wash cloths. While the resident was on her back now, CNA 27 wiped the left groin area in the front, then folded the wash cloth and wiped the right groin area, folded again, and wiped down the center of the resident's front. CNA 27 repeated that process again when CNA 25 handed her more wet wash cloths. CNA 27 took off her gloves and put on new ones on without sanitizing her hands, put on the resident's pants and shirt, and took off her gloves. (continued on next page)

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F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	During an interview on 2/12/25 at 1:38 P.M., the Infection Preventionist indicated she would expect staff to wipe from clean to dirty or front to back, change gloves during incontinence care between clean and dirty tasks and after touching items before incontinence care, and to sanitize hands between glove changes during incontinence care. 38770 2. On 2/7/25 at 8:30 A.M., the ADON was observed to take the medication cart keys from the night shift nurse. At that time, she indicated they had a staff member to call in that morning, and she had just gotten there. On 2/7/25 at 9:37 A.M., the ADON was observed to prepare a glucometer machine for an accucheck for Resident D. She obtained the machine from the medication cart, placed it on top of the cart, and prepared the strip and lancet before entering the resident's room. The glucometer machine had not been cleaned during observation since 8:30 A.M. At that time, the ADON indicated the glucometer machines were cleaned in between each resident but could not say if it had been cleaned after the most recent resident it was used for as she had just taken over the cart that morning. The ADON used the glucometer machine to do Resident D's accucheck without cleaning it. On 2/13/25 at 10:01 A.M., the Director of Nursing (DON) indicated she would expect staff to clean the glucometer machine at the beginning of their shift and between each resident use. 46882 3. On 2/10/25 at 9:45 A.M., Resident H's clinical record was reviewed. Diagnoses included, but were not limited to dementia, anxiety disorder, and psychotic disorder. The most current Quarterly Minimum Data Set (MDS) assessment, dated 11/28/24, indicated Resident H was unable to complete the cognitive test due to resident rarely or never understood, dependent (Helper does ALL of the effort. Resident does none of the effort to complete the activity) on staff for bed mobility, transfers and toilet use, required substantial/maximal assistance (Helper does MORE THAN HALF the effort) for eating, and had one Stage 3 Pressure Ulcer. Physician Orders included, but were not limited to the following: TX (treatment) to Right Elbow: Cleanse area with NSS (Normal Saline Solution) or Wound Wash, pat dry, apply Collagen Powder to wound bed, insert Calcium Alginate into wound bed, then cover with ABD (Abdominal) pad, and cover with elbow foam dressing, wrap with Kerlix and secure with paper tape Daily and PRN (as needed), every day shift for Wound Care AND as needed for when soiled, loose, dislodged, dated 2/6/2025. Enhanced Barrier Precautions related to wound No directions specified for order, dated 1/9/2025 (continued on next page)

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F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	On 2/12/25 at 11:00 A.M., Licensed Practical Nurse (LPN) 37 and Agency Certified Nurse Aide (CNA) 39 were observed doing a dressing change to Resident H's right elbow. Both LPN 37 and Agency CNA 39 washed their hands over 20 seconds. They did not put gowns on. LPN 37 and Agency CNA 39 put gloves on, LPN 37 removed elbow pad, put sleeve of shirt up, and at that time indicated she had given Resident H a pain medication before starting. LPN 37 removed her gloves and put in the trash can, cleaned hands with sanitizer, put on clean gloves, removed dressing and put in trash can, cleaned wound with wound cleaner and a 4 x 4 gauze, removed gloves and put in trash can, washed hands, put on clean gloves, poured collagen powder in medicine cup and poured on wound, removed gloves and put in trash can, cleaned hands with sanitizer, put on clean gloves, cut section of calcium alginate dressing and placed in wound bed, ABD pad placed over wound and wrapped with Kerlex gauze, removed gloves and washed hands, put on clean gloves, put tape on gauze, did not date or initial dressing. LPN 37 removed gloves and put in trash can, washed hands at sink. LPN 37 indicated the wound to the elbow was looking better, had no drainage and was caused from the resident leaning her elbows on the wheelchair arms and that was why they put foam elbow pads on both elbows now. Resident H had skin prep applied to left heel daily but she had already done that. LPN 37 put the elbow pad back on right arm. Agency CNA 39 took trash bag out of trash can and tied it shut, put new trash bag in, put trash in utility room. There was no Enhanced Barrier Precautions sign on the wall or door outside of Resident H's room. During an interview on 2/13/25 at 10:25 A.M., the Wound Nurse indicated Resident H has an open elbow wound and would expect her to be on EBP. Staff should wear gown, mask, gloves when doing care and dressing changes. 4. On 2/10/25 at 1:30 P.M., Resident G's clinical record was reviewed. Diagnoses included, but were not limited to anemia and dementia. The most current Quarterly Minimum Data Set (MDS) assessment, dated 12/6/24 indicated Resident G had moderate cognitive impairment, required set up or clean up (Helper sets up or cleans up; resident completes activity) assistance with eating, bed mobility and transfers, and required substantial/maximal (Helper does MORE THAN HALF the effort) assistance with toilet use, and had an indwelling catheter. Physician Orders included, but were not limited to the following: may remove Foley catheter, if does not void in 8 HOURS reinsert Foley catheter 14 French (size of catheter) 10 cc (cubic centimeters) balloon, dated 1/31/2025 Enhanced Barrier Precautions (EBP) related to Foley Catheter, dated 1/9/2025 change catheter PRN (as needed) when there is leakage, call doctor when there's discomfort before changing, every 24 hours as needed for preventive, dated 9/20/2024 (continued on next page)

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	155042	A. Building B. Wing	02/13/2025

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F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	On 02/12/25 at 11:17 A.M., Agency Certified Nurse Aide (CNA) 39 was observed during catheter care for Resident G. Agency CNA 39 washed her hands at sink, explained what she was going to do, filled water basins with warm water and set them on the bedside table, and put gloves on. There was an EBP sign on the wall outside of Resident G's room, but Agency CNA 39 did not put gown on. Agency CNA 39 used clean washcloth with skin cleaner and water, washed head of penis, washed head of penis again, used a clean washcloth and rinsed area, used another washcloth with skin cleanser and washed catheter tubing, used clean washcloth to rinse tubing, used towel to dry area, resident stood so leg bag could be emptied, Agency CNA 39 removed gloves and washed hands, put clean gloves on, opened leg bag and emptied urine into urinal, cleaned tip of bag and closed leg bag, emptied urinal, and put dirty linens in trash bag, emptied and dried water basins, emptied trash can and tied bag, and put new trash bag in can, and carried both trash bags to utility room. During an interview on 2/12/25 at 1:38 P.M., the Infection Preventionist (IP) indicated residents on EBP would be residents with indwelling devices, open wounds with dressings, wounds that are chronic but not all wounds require EBP. She indicated she would expect staff to wear gowns and gloves with catheter care and when doing care for anyone on EBP. On 2/12/25 at 2:47 P.M., the Administrator provided an Enhanced Barrier Precautions policy, revised on 5/7/24, which indicated Enhanced Barrier Precautions (EBP) refer to an infection control intervention designed to reduce transmission of multidrug-resistant organisms that employs targeted gown and glove use during high contact resident care activities .EBP are indicated for residents with any of the following: Chronic wounds and/or indwelling medical devices even if the resident is not known to be infected or colonized with a multidrug-resistant organism (MDRO) .Examples of chronic wounds include, but are mot limited to: pressure ulcers, diabetic foot ulcers, unhealed surgical wounds and venous stasis ulcers .For residents for whom EBP are indicated, EBP is employed when performing the following high-contact resident care activities, especially when care is being bundled: .Device care or use: .urinary catheter .Wound care: any chronic skin opening requiring a dressing . On 2/13/25 at 11:24 A.M., a current Incontinence Care Policy was requested and not provided. On 2/13/25 at 12:19 P.M., a current Hand Hygiene Policy, revised 7/30/24, was provided by the Administrator and indicated . Examples of when to perform hand hygiene (either alcohol based hand sanitizer or handwashing): at room entry, before performing an aseptic task, before exiting room, after contact with blood, body fluids or excretions, mucous membranes, non-intact skin, or wound dressings . after glove removal . On 2/7/25 at 2:20 P.M., the [NAME] President (VP) of Operations provided a current Glucometer Cleaning policy, dated 8/1/16, that indicated The blood glucose monitor should be cleaned and disinfected between each resident test This citation relates to Complaint IN00449788 and IN00452999. 3.1-18(b) 3.1-18(j) 3.1-18(l)

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	155042	A. Building B. Wing	02/13/2025

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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 0926 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Have policies on smoking. 38770 Based on observation, interview, and record review, the facility failed to ensure smoking policies related to smoking safety were enforced for 2 of 2 random observation of smoking. (Resident K, Resident 51, Resident 20) Finding includes: During a random continuous observation on 2/5/25 from 11:05 A.M. through 11:45 A.M., the following was observed on the G/H/I Hall: 11:05 A.M. Resident K, Resident 51, and Resident 20 were observed all sitting in wheelchairs in the common area around the nurses station. Resident 51 indicated it was a usual occurrence to wait for staff to take them out to smoke. He indicated they were supposed to go out at 11:00 A.M., but since it was dietary's turn to take them, sometimes that smoke time was skipped because dietary did not have time to take them. At that time, a form was observed posted by the nurses station that indicated 11:00 A.M. smoke break with dietary beside the time. 11:08 A.M. Registered Nurse (RN) 17 called dietary and indicated they needed someone to come and take the smokers out. 11:18 A.M. Certified Nurse Aide (CNA) 27 indicated if the department that was supposed to take the smokers out did not show up after about ten to fifteen minutes, staff would typically call them back. 11:19 A.M. Resident 51 asked Housekeeper 21 if she could take the residents out to smoke. Housekeeper 21 agreed and indicated she would go lock down her cart and go with them. 11:21 A.M. Housekeeper 21 indicated to the residents waiting to smoke that she was waiting on the nurse to get their cigarettes out for them. 11:22 A.M. RN 17 observed obtaining cigarettes from the medication room for the smokers. 11:24 A.M. Resident K, Resident 51, and Resident 20 observed to go out the door by the nurses station with Housekeeper 21. The residents were not offered a smoking apron or any other protective devices while outside, and none were observed in the area. The residents were wearing appropriate outer wear. The residents were observed smoking under a covered patio area up against the facility. No ashtray was observed. A sign was observed hanging from the patio railing that indicated non-designated smoking area with a picture of a cigarette in a circle with a line through it that indicated no smoking. Another sign was observed on the door that indicated no smoking within 7 feet of the facility. A stone plant pot was observed with used cigarette butts in it on the patio. (continued on next page)

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	02/13/2025

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 0926 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Resident K was observed to toss 2 used cigarette butts into the stone plant pot without putting them out first, and Housekeeper 21 was observed to toss one of Resident 20's cigarette butts in the pot without first putting it out. The pot was observed to have dried plant material and dirt inside of it. Resident 51 was observed to go in the building prior to the rest of the smokers being done smoking. When the residents were finished smoking, Housekeeper 21 was observed to take Resident 20 inside the building, and left Resident K outside on the patio for three minutes, until he wheeled himself inside the building. On 2/6/25 at 11:17 A.M., the Social Services Director (SSD) was observed to take residents to smoke from the G/H/I Hall. The residents were led to a shed with the front completely open. An ashtray was observed just outside of the shed. Prior to smoking, the residents were not offered an apron to wear for safety. At that time, the smoke times form was still posted by the nurses station that indicated dietary to take the residents to smoke at 11:00 A.M. On 2/7/25 at 11:00 A.M., the Dietary Manager indicated they did not have enough time to take the residents to smoke so they had quit taking them a couple of days prior. She indicated that administration was aware of the change. On 2/13/25 at 9:22 A.M., the Administrator indicated the 11:00 A.M. smoke time for G/H/I Hall was recently changed for laundry staff to take the residents out to smoke. At the time it was decided, all departments heads were aware and a part of the meeting. At that time, the Administrator indicated she was unaware of the form posted on the G/H/I Hall that indicated what department was responsible for taking the residents to smoke. At that time, she indicated residents were only to smoke in designated areas, and not on the patio of the facility. On 2/10/25 at 2:59 P.M., the Administrator provided a current Smoking Safety policy, dated 1/19/21, that indicated . the facility will designate outdoor areas approved for smoking by residents, visitors and staff . ashtrays of noncombustible material and safe design shall be provided in all areas where smoking is permitted. Metal containers with self-closing cover devices into which ashtrays can be emptied shall be readily available to all areas where smoking is permitted . Appropriate safety devices, including but not limited to, smoking aprons, fire blanket and a fire extinguisher shall be readily available . smoking areas must not be near entrance where visitors, vendors or employees enter or exit This citation relates to Complaint IN00452999.