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	03/19/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP COD
APERION CARE VINCENNES	3801 OLD BRUCEVILLE ROAD, BOX 136 VINCENNES, IN 47591

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIE (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
E 0000 Bldg. --	A Post Survey Revisit (PSR) to the Emergency Preparedness Survey that exited on 02/06/24 was conducted by the Indiana Department of Health in accordance with 42 CFR 483.73. Survey Dates: 03/19/24 Facility Number: 000016 Provider Number: 155042 AIM Number: 100291500 At this PSR to the Emergency Preparedness survey, Willow Manor was found in compliance with Emergency Preparedness Requirements for Medicare and Medicaid Participating Providers and Suppliers, 42 CFR 483.73 The facility has a capacity of 170 certified beds and had a census of 81 at the time of this visit. Quality Review completed on 03/19/24	E 0000		
K 0000 Bldg. 01	A Post Survey Revisit (PSR) to the Life Safety Code Recertification and State Licensure Survey that exited on 02/06/24 was conducted by the Indiana Department of Health in accordance with 42 CFR 483.90(a). Survey Dates: 03/19/24 Facility Number: 000016 Provider Number: 155042 AIM Number: 100291500	K 0000		

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE	TITLE	(X6) DATE
Ashli Wesley	Administrator	04/02/2024

Any defiencystatement ending with an asterisk (*) denotes a deficency which the institution may be excused from correcting providing it is determin other safegaurds provide sufficient protection to the patients. (see instructions.) Except for nursing homes, the findings stated above are disclosable following the date of survey whether or not a plan of correction is provided. For nursing homes, the above findings and plans of correction are disclo days following the date these documents are made available to the facility. If deficiencies are cited, an approved plan of correction is requisite to continued program participation.

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	155042	A. BUILDING 01 B. WING	03/19/2024

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	At this PSR to the Life Safety Code survey, Willow Manor was found not in compliance with Requirements for Participation in Medicare/Medicaid, 42 CFR Subpart 483.90(a), Life Safety from Fire and the 2012 edition of the National Fire Protection Association (NFPA) 101, Life Safety Code (LSC), Chapter 19, Existing Health Care Occupancies and 410 IAC 16.2. This one story facility with a lower level was determined to be of Type V (000) construction and was fully sprinklered. The facility has a fire alarm system with hard wired smoke detectors in the corridors, spaces open to the corridors, and all resident sleeping rooms. The facility has a capacity of 170 and had a census of 81 at the time of this survey. All areas where the residents have customary access were sprinklered, including the smoking building, and all areas providing facility services were sprinklered, except, an enclosed metal carport used for storage of landscaping equipment, and a wood minibarn used for storage of biohazardous waste. Quality Review completed on 03/19/24			
K 0271 SS=E Bldg. 01	NFPA 101 Discharge from Exits Discharge from Exits Exit discharge is arranged in accordance with 7.7, provides a level walking surface meeting the provisions of 7.1.7 with respect to changes in elevation and shall be maintained free of obstructions. Additionally, the exit discharge shall be a hard packed all-weather travel surface. 18.2.7, 19.2.7 Based on observation and interview, the facility	K 0271	What Corrective Action(s) Will Be	04/30/2024

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	155042	A. BUILDING 01 B. WING	03/19/2024

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	failed to maintain the walking surface for 1 of at least 18 exit discharge areas. This deficient practice could affect at least 20 residents, as well as staff and visitors. Findings include: Based on observations on 03/19/24 between 9:45 a.m. and 11:45 a.m. during a tour of the facility with the Maintenance Director, at the end of the sidewalk and the beginning of the parking lot from the F Wing exit there was an eight foot by eight foot section of the concrete that had dropped between 1 and 2 inches on one side and 3 to 4 inches on another side. The level change in the concrete could be a tripping hazard while exiting from this area in the event of an emergency. The facility had already placed a wood sawhorse in this area to warn people of the uneven surface. Based on interview at the time of observation, the Maintenance Director said the facility was already aware of the uneven surface and are in the process of figuring out how to correct the issue. This finding was reviewed with the Maintenance Director during the exit conference. This deficient practice was cited on 02/05/24 and 02/06/24. The facility failed to implement proper corrective action. 3.1-19(b)		Accomplished for Those Residents Found to Have Been Affected by The Deficient Practice: The facility ensures that all discharges from exits are free from obstruction. Administrator & Maintenance Director have received quotes from local companies for the repair. How Other Residents Having the Potential to Be Affected by The Same Deficient Practice Will Be Identified and What Corrective Action(s) Will Be Taken: All residents, staff and visitors have the potential to be affected by this alleged deficient practice. What Measures Will Be Put into Place and What Systemic Changes Will Be Made to Ensure That the Deficient Practice Does Not Recur: The facility will continue with on-going visual inspections to identify and resolve any apparent issues in accordance with regulations. How The Corrective Action(s) Will Be Monitored to Ensure the Deficient Practice Will Not Recur: The Maintenance Director will audit monthly x6 months to	

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			ensure the facility complies. Any concerns will be addressed as discovered and reported to Administrator. If any patterns are identified, an action plan will be written immediately and reported at the monthly QAPI. Any written action plan will be monitored by the Administrator and/or Designee monthly until resolved and substantial compliance is achieved. Date of Completion: 4/30/24	