STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER	X2) MULTIPLE CONSTRUCTION	X3) DATE SURVEY COMPLETED
	155042	A. BUILDING 00 B. WING	08/16/2024

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
F 0000 Bldg. 00	This visit was for the Investigation of Complaints IN00439625, IN00439414, and IN00437748. IN00439625: Federal/State deficiencies related to the allegations are cited at F690. IN00439414: Federal/State deficiencies related to the allegations are cited at F690. IN00437748: Federal/State deficiencies related to the allegations are cited at F921. Survey dates: August 15 & 16, 2024 Facility number: 000016 Provider number: 155042 AIM number: 100291500 Census Bed Type: SNF/NF: 80 Total: 80 Census Payor Type: Medicare: 8 Medicaid: 62 Other: 10 Total: 80 These deficiencies reflect State findings cited in accordance with 410 IAC 16.2-3.1. Quality review completed on August 23, 2024.	F 0000	This plan of correction is submitted as required under Federal and State regulation and statues applicable to long term care providers. This plan of correction does not constitute an admission of liability on the part of the facility, and such liability is hereby specifically denied. The submission of the plan does not constitute an agreement by the facility that the surveyor's findings or conclusions are accurate, that the findings constitute a deficiency, or that the scope or severity regarding any of the deficiencies cited are correctly applied. The facility respectfully requests consideration of a desk review and paper compliance for this plan of correction.	
F 0690 SS=D Bldg. 00	483.25(e)(1)-(3) Bowel/Bladder Incontinence, Catheter, UTI Based on observation, interview, and record review, the facility failed to ensure routine catheter care and ostomy care was completed for 3	F 0690	It is the practice of this facility to ensure routine catheter care and ostomy care is provided per the	09/13/2024

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE	TITLE	(X6) DATE
Michael Meadows	Administrator	09/04/2024

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	of 3 residents reviewed for catheter/ostomy care. Routine catheter and ostomy care was not provided per the residents' plan of care. (Resident C, Resident D, Resident F) Finding includes: 1. Resident C was observed up in a wheelchair in her room on 8/16/24 at 10:00 A.M.. A catheter drainage bag was clipped to the underside of the resident's wheelchair. Resident C indicated that she also had a colostomy and that she had recently waited through multiple shifts for nursing staff to change the colostomy bag. A record review on 8/16/24 at 10:30 A.M., indicated that Resident C's diagnoses included, but were not limited to, paraplegia, neuromuscular dysfunction of bladder, and stage 4 pressure ulcer of sacral region. Resident C's most recent Quarterly Minimum Data Set (MDS) Assessment, dated 6/1/24, indicated the resident had no cognitive impairment, had an indwelling catheter, and an ostomy. Resident C's physician orders included, but were not limited to, catheter care every shift (2/20/24), and colostomy care every shift (2/20/24). Resident C's care plan included, but was not limited to, resident has indwelling catheter due to neuromuscular dysfunction with an intervention including catheter care per policy (12/1/21) and resident has colostomy with an intervention that included empty colostomy bag every shift (12/2/21). Resident C's treatment administration record (TAR) for July, 2024 indicated that the physician's		resident's plan of care including the proper documentation of routine catheter care and ostomy care that is provided to each resident. What corrective action(s) will be accomplished for those residents found to have been affected by the deficient practice: Residents C, D, and F, that were identified as being affected during the survey, have received treatment as indicated in each resident's plan of care with no negative outcomes noted. Each treatment that was administered to the affected residents has been documented appropriately. The plan of care has been reviewed for each resident that was identified during this survey and updated as needed. Nursing staff were in serviced on providing catheter care and ostomy care per each resident's plan of care including the proper documentation of catheter care and ostomy care that is provided to each resident. 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:	

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	orders to provide catheter care and colostomy care every shift was not documented as completed on 7/6/24 (day-shift), 7/9/24 (nightshift), and 7/15/24 (night shift). 2. Resident D was observed lying in bed in his room on 8/16/24 at 12:00 P.M. A catheter drainage bag was clipped to the side of the bed. Resident D indicated that he fills the drainage bag often and has to tell staff to empty due to staff not emptying the catheter routinely. Resident D indicated staff rarely come in to provide catheter care including cleaning the catheter tubing and insertion site. A record review on 8/16/24 at 12:30 P.M., indicated that Resident D's diagnoses included, but were not limited to, benign prostatic hyperplasia with lower urinary tract symptoms and neuromuscular dysfunction of bladder. Resident D's most recent Quarterly MDS Assessment, dated 8/7/24, indicated the resident had no cognitive impairment and had an indwelling catheter. Resident D's physician orders included, but were not limited to, catheter care every shift (1/29/24). Resident D's care plan included, but was not limited to, resident has indwelling catheter due to neuromuscular dysfunction with an intervention including catheter care every shift (2/11/24). Resident D's treatment administration record (TAR) for July & August, 2024 indicated that the physician's orders to provide catheter care every shift was not documented as completed on 7/6/24 (day-shift), 8/3/24 (evening shift), 8/7/24 (day-shift), 8/8/24 (day shift), and 8/12/24 (evening shift).		All residents that have a catheter or ostomy have the potential to be affected by the alleged deficient practice. An audit of the Treatment Administration Record (TAR) of all residents that have a catheter or ostomy was completed with individual education provided for any missing documentation of treatment that was provided. What measures will be put into place and what systemic changes will be made to ensure that the deficient practice does not recur. The DON or designee will audit all Treatment Administration Records (TAR's) of residents that have a plan of care that requires routine catheter care or ostomy care to ensure that the treatment has been properly documented. Any discrepancies that are found from these audits will be corrected and education provided to ensure routine catheter care and ostomy care has been administered and properly documented. How the corrective actions will be monitored to ensure the deficient practice does not recur. The DON or designee will complete a documentation audit of residents with a plan of care for	

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	3. Resident F was observed sitting up in recliner in her room on 8/15/24 at 11:10 A.M.. A catheter drainage bag was clipped to the lower leg. Resident F indicated that she provides her own catheter care. A record review on 8/16/24 at 10:50 A.M., indicated that Resident F's diagnoses included, but were not limited to, hemiplegia, chronic kidney disease, and cystocele. Resident F's most recent Quarterly Minimum Data Set (MDS) Assessment, dated 6/24/24, indicated the resident had moderately impaired cognition, an indwelling catheter, and required substantial to maximum assist with toileting hygiene. Resident F's physician orders included, but were not limited to, ensure Foley catheter care is provided every shift (3/31/23). Resident F's care plan included, but was not limited to, resident has indwelling catheter due to cystocele/prolapsed bladder with an intervention including catheter care every shift (4/3/23). Resident F's treatment administration record (TAR) for July, 2024 indicated that the physician's orders to provide catheter care and colostomy care every shift was not documented as completed on 7/6/24 (day-shift), 7/9/24 (nightshift), and 7/15/24 (night shift). During an interview on 8/16/24 at 12:15 P.M., RN 5 indicated staff assist Resident F with her catheter care and that routine catheter care included cleaning the catheter tubing and insertion site. RN 5 indicated if a routine order is not completed, staff should document in the resident's record		routine catheter care or ostomy care 3 times per week X 4 weeks, then weekly X 8 weeks to ensure administration and proper documentation. In addition to the documentation audit, the DON or designee will interview 3 random residents with a plan of care for routine catheter care or ostomy care 5 days per week X 4 weeks, then weekly X 8 weeks to ensure treatment has been administered. Any discrepancies that are found from these audits will be corrected and education provided. The findings of these audits and any corrective action required will be discussed during the monthly QAPI meeting.	

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	why the order was unable to be completed. On 8/16/24 at 1:10 P.M., the Facility Administrator supplied a copy of an undated facility policy titled Colostomy Care, and a policy titled Urinary Catheter Care, dated 2/14/19. The Colostomy Care policy included, "...Colostomy Site Care a) Colostomy site care will be provided... as ordered by [Medical Doctor]." The Urinary Catheter Care policy included, "...routine hygiene is appropriate..." This citation relates to complaints IN00439625 and IN00439414. 3.1-41(a)(2) 3.1-47(a)(3)			
F 0921 SS=E Bldg. 00	483.90(i) Safe/Functional/Sanitary/Comfortable Environ Based on observation, interview, and record review, the facility failed to ensure a safe, sanitary, and homelike environment in 3 of 4 resident halls observed and 2 of 3 shared restrooms observed. Resident rooms were missing window trim, had stained toilet bowels, and were missing thresholds between doorways, shared shower rooms were missing light covers, cove base, corner trim, had cracked or broken tiles, had a broken switch plate, and had old screw holes in the walls, and hall floors were missing baseboard and had worn spots and paint splatters. (C/D Halls and shower rooms, GHI shower room, Room 41, Room 50, Room 52, Room 56) Findings includes: 1. During an observation on 8/15/24 at 11:00 A.M., Room 50's restroom contained a stained commode	F 0921	It is the practice of this facility to ensure a safe, sanitary, and homelike environment. What corrective action(s) will be accomplished for those residents found to have been affected by the deficient practice: No residents were identified as being affected by the alleged deficient practice. 1.The Commode in room 50 has been cleaned and discoloration has been removed. 2. The white paint splatters on Hall D have been removed from the floor and sections of flooring that had worn spots have been replaced, the	09/13/2024

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	with the bowl having dark discolorization. 2. During an observation on 8/15/24 at 11:15 A.M., Hall D was observed to have white paint splatters on the hallway floor as well as what appeared to be worn spots through the flooring showing the white spots throughout the hall. Baseboard was missing from room 50 to the next doorway of a storage closet. 3. During an observation on 8/15/24 at 11:30 A.M., a shared shower room on the C/D halls contained broken floor tiles near the base of the sink and in the main shower stall. 4. During an observation on 8/15/24 at 2:20 P.M., a second shared room on the C/D halls contained a broken switch plate and a build up of dust in the overhead vent. 5. During an observation on 8/15/24 at 2:40 P.M., a shared shower room on the G/H/I halls was missing a corner trim cover near the commode, had 14 old screw holes on the wall across from the commode, light covers were missing from the light fixtures towards the back of the shower room over a shower stall and towards the front of the room near the doorway, and the wall cove base was missing near the shower room door. 6. During an observation on 8/16/24 at 10:00 A.M., Room 52 was missing a piece of window trim and the edges of the tiles were cracked or broken near the bathroom door. 7. During an observation on 8/16/24 at 10:30 A.M., Room 41 and Room 56 were missing the threshold in the doorways entering the rooms. During an interview on 8/16/24 at 10:15 A.M.,		cove base has been replaced in the corridor between room number 50 and the doorway of a storage closet. 3. Broken floor tiles near the base of the sink and in the main shower stall in the shared shower room on C and D hall have been replaced. 4. A broken light switch in the second shared shower room on C and D hall has been replaced and dust on overhead vent has been cleaned. 5. In G, H, and I shower room the missing corner trim near the commode has been replaced, the 14 holes identified have been repaired, the missing light covers have been replaced towards the back of the shower room over a shower stall and towards the front of the room near the doorway, and cove base was replaced near the shower room door. 6. In room 52 the window trim was replaced and the tiles near the bathroom door have been replaced. 7. The threshold in the doorways entering rooms 41 and 56 was replaced. 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 have the potential to be affected by the same alleged deficient practice. A complete audit of facility spaces will be completed to ensure that the	

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	Maintenance 4 indicated that the facility was short on maintenance personnel and that one maintenance staff had recently left employment. Maintenance 4 indicated that maintenance staff completes routine checks on rooms weekly but rely on staff to alert them of missing or broken items in the facility. The white spots on the flooring on the C/D hall were from the floor tech staying in one spot too long with the floor cleaning machine and "burning" through the top layer of flooring. On 8/16/24 at 10:50 A.M., the Facility Administrator supplied an undated facility policy titled Physical Plant - Daily Inspections. The policy included, "Buildings and grounds are to be inspected daily... As areas needing repair or attention are identified, they should be dealt with immediately..." This citation relates to complaint IN00437748. 3.1-19(a)(4)		same alleged deficiencies are not present in any space not identified. All staff will be in serviced on the location and use of work orders, paper and digital, to ensure maintenance is aware of any areas that need repair. What measures will be put into place and what systemic changes will be made to ensure that the deficient practice does not recur. Staff from all departments will be in serviced on the location and use of work orders, paper and digital, to ensure maintenance is aware of any areas that need repair. Maintenance will prioritize work orders and ensure that all repairs are completed timely. How the corrective actions will be monitored to ensure the deficient practice does not recur. The Maintenance Director or designee will audit common spaces while doing safety rounds 5 days a week X 4 weeks with any issues reported at the morning meeting, then weekly X 8 weeks. Any discrepancies that are found from these audits will be corrected as soon as possible. The findings of these audits will be discussed during the monthly QAPI meeting.	