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| | 155042 | A. BUILDING 00<br>B. WING | 12/06/2024 |

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| APERION CARE VINCENNES | 3801 OLD BRUCEVILLE ROAD, BOX 136<br>VINCENNES, IN 47591 |

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| F 0000<br><br>Bldg. 00 | This visit was for the investigation of complaints IN00448562, IN00447323, IN00447164, IN00446746, IN00444100, IN00444147, and IN00442047.<br><br>IN00448562: Federal/State deficiencies related to the allegations are cited at F812 and F921<br>IN00447323: No deficiencies are cited related to the allegations.<br>IN00447164: Federal/State deficiencies related to the allegation are cited at F812.<br>IN00446746: Federal/State deficiencies related to allegations are cited at 921<br>IN00444100: No deficiencies are cited related to the allegations.<br>IN00444147: No deficiencies are cited related to the allegations.<br>IN00442047: Federal/State deficiencies related to the allegations are cited at F812.<br><br>Deficiencies unrelated are cited.<br><br>Survey dates: December 4, 5, & 6, 2024<br><br>Facility number: 000016<br>Provider number: 155042<br>AIM number: 100291500<br><br>Census Bed Type:<br>SNF/NF: 77<br>Total: 77<br><br>Census Payor Type:<br>Medicare: 5<br>Medicaid: 60<br>Other: 12<br>Total: 77 | 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.<br><br>The facility respectfully requests consideration of a desk review and paper compliance for this plan of correction. | |

| LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE | TITLE | (X6) DATE |
|---|---|---|
| Dena Kerschner | RVPO | 12/31/2024 |

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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| | These deficiencies reflect State findings cited in accordance with 410 IAC 16.2-3.1.<br><br>Quality review completed on December 12, 2024. | | | |
| F 0812<br>SS=E<br>Bldg. 00 | 483.60(i)(1)(2)<br>Food Procurement,Store/Prepare/Serve-Sanitary<br>Based on observation, interview, and record review, the facility failed to ensure a sanitary environment was maintained in accordance with professional standards for food services safety during 2 of 2 kitchen observations. Kitchen staffs' hair was not fully contained within a hairnet, and kitchen staff failed to complete proper hand hygiene.<br><br>Findings include:<br><br>1. During an observation on 12/4/24 at 12:00 P.M. the DM (Dietary Manager) was in the kitchen wearing a hairnet. The DM's hair was not fully contained by the hairnet with loose strands of hair coming out the front and back of the hairnet.<br><br>During an observation on 12/5/24 at 12:00 P.M., the DM and Cook 4 were preparing for lunch service. During service, the DM and Cook 4's hair was not fully contained by their hairnet with loose strands exposed.<br><br>During an interview on 12/5/24 at 3:40 P.M., the Facility Administrator indicated she had previously mentioned to the DM that her hair must be covered by the hairnet.<br><br>2. During a kitchen observation on 12/5/24 at 11:59 A.M., a printed sign above the kitchen handwashing sink indicated that proper hand | F 0812 | Please accept the following as the facility's credible allegation of compliance. This plan of correction does not constitute any admission of guilt or liability by the facility and is submitted only in response to the regulatory requirements.<br><br>***What corrective actions have been accomplished for those residents found to have been affected by the deficient practice?***<br><br>No residents were affected by the alleged deficient practice<br><br>**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:**<br>All residents have the potential to be affected by the alleged deficiency. Dietary staff educated on complete and thorough wearing of hairnets and proper handwashing. Audits and observations being completed 5 times a week for 12 weeks and | 12/23/2024 |

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| | washing included washing hands for at least 20 seconds.<br><br>During an observation on 12/5/24 at 12:02 P.M., prior to food service, cook 4 washed hands with a 9 second scrub time.<br><br>During an observation on 12/5/24/at 12:03 P.M., the DM washed hands with a scrub time of 6 seconds.<br><br>During an observation on 12/5/24 at 12:04 P.M., the DM exited the kitchen and then returned with a bowl of ice. The DM then washed hands while allowing no scrub time between adding soap to her hands and then immediately rinsing the soap from her hands.<br><br>During an observation and interview on 12/6/24 at 2:20 P.M., CNA 5 was pushing a food cart and hydration cart through the GHI dining room. CNA 4 indicated that during meal service, staff should wash their hands for a time period long enough to sing the alphabet twice.<br><br>On 12/6/24 at 10:00 A.M., the Facility Administrator supplied a facility policy titled, Hair Restraints, dated 2020. The policy included, "Hair restraints shall be worn by all Dining Services staff when in food production areas, dishwashing area, or when serving food..." The Facility Administrator also supplied a policy titled, Proper Hand Washing and Glove Use, dated 2020. The policy included, "1. Instructions will be posted over each hand washing station outlining the proper procedure for washing hands. 2. The proper procedure for washing hands is as follows: a. Turn on water as hot as comfortable. b. Wet hands and apply soap. c. Scrub for 15 to 20 seconds or more: getting under nails, between | | then 3 times a week for 12 weeks to ensure deficient practice does not recur.<br><br>**What measures will be put into place and what systemic changes will be made to ensure that the deficient practice does not recur.**<br><br>Dietary Staff have been educated on complete and through wearing of Hairnets.<br><br>Dietary Staff have been educated on the Facilities Proper Handwashing and Glove Use Policy including complete handwashing.<br><br>Staff have been educated on the Facilities Proper Handwashing and Glove Use Policy including handwashing prior to entering the kitchen from any other location.<br><br>**How the corrective actions will be monitored to ensure the deficient practice does not recur.**<br><br>Administrator/Designee will perform 5 observations a week for 12 weeks and then 3 times a week for 12 weeks to ensure through wearing of Hairnets.<br><br>Administrator/Designee will perform 5 observations a week for | |

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| | fingers, and all exposed areas, such as back of hands and forearms... 3. All employees will wash hands upon entering the kitchen from any other location... 4. Employees will wash hands before and after handling foods..."<br><br>This citation relates to complaints IN00448562, IN00447164, and IN00442047.<br><br>3.1-21(i)(2)<br>3.1-21(i)(3) | | 12 weeks and then 3 times a week for 12 weeks to ensure proper and adequate handwashing in the kitchen.<br><br>Administrator/Designee will perform 5 observations a week for 12 weeks and then 3 times a week for 12 weeks to ensure proper and adequate handwashing prior to entering the kitchen.<br><br>The results of the above audits will be reviewed in the Quality Assurance Meeting monthly until 100% compliance is achieved for 6 consecutive months. The QAA Committee will identify any trends or patterns and make recommendations to revise the plan of correction as indicated.<br>.<br>The Administrator will monitor completion of the Quality Assurance monitoring. | |
| F 0842<br>SS=D<br>Bldg. 00 | 483.20(f)(5), 483.70(i)(1)-(5)<br>Resident Records - Identifiable Information<br><br>Based on interview and record review, the facility failed to ensure resident records were accurate and complete for 1 of 3 residents reviewed for pressure wounds and 1 of 3 residents reviewed for diabetic care. Medication Administration Records (MAR) and Treatment Administration Records (TAR) were not documented completely. (Resident D)<br><br>Finding includes: | F 0842 | what corrective action(s) will be accomplished for those residents found to have been affected by the deficient practice; Resident D has been assessed with no negative outcome noted. Licensed Nursing Staff have been educated on the Facilities Medication Administration General Guidelines if a medication is withheld, refused, not available or | 12/23/2024 |

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| | During record review on 12/6/24 at 10:30 P.M., Resident D's diagnoses included, but were not limited to, diabetes mellitus, morbid obesity, and chronic kidney disease.<br><br>Resident D's most recent quarterly Minimum Data Set (MDS) assessment dated, 11/8/24, indicated the resident received insulin.<br><br>Resident D's care plan included, but was not limited to, Resident has a left toe infection (created 9/30/24) and resident has diabetes mellitus (created 12/18/20).<br><br>Resident D's physician orders included, but were not limited to, treatment to left, first toe. Cleanse area with wound cleanser or normal saline solution, pat dry. Apply Betadine twice a day and as needed, every day and night shift (started 10/17/24), and Humalog Injection (insulin) Solution 100 units/milliliter (ml) inject per sliding scale (started 12/8/23).<br><br>A review of Resident D's TAR indicated that the resident's order for wound treatment to the left toe was not documented as completed, and contained no documentation as to why it was not completed on the dates of:<br>10/27/24 (day shift), 11/18/24 (day shift), 11/20/24 (day shift), 11/21/24 (day shift), 11/23/24 (day shift), and 12/2/24 (day shift).<br><br>A review of Resident D's MAR indicated that the resident's order for sliding scale insulin was not documented as administered and contained no documentation as to to why the medication was not administered. The record also lacked required documented blood sugar levels for the following dates in November, 2024: 11/6/24 (evening), 11/13/24 (noon), 11/23/24 (noon). | | given at a time other than the schedule time, then an explanatory note is entered.<br>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;<br>All residents with Pressure Wounds and Diabetic Care have the potential to be affected by the alleged deficient practice.<br>DON/Designee will perform 5 Medical Record reviews a week for 12 weeks and then 3 times a week for 12 weeks to ensure documentation after Medication/treatment administration is completed, if a dose or medication is withheld, refused, not available or given at a time other than the scheduled time, than an explanatory note is completed.<br>what measures will be put into place and what systemic changes will be made to ensure that the deficient practice does not recur;<br>Licensed Nursing Staff have been educated on the Facilities Medication Administration General Guidelines if a medication is withheld, refused, not available or given at a time other than the schedule time, then an explanatory note is entered.<br>how the corrective action(s) will be monitored to ensure the deficient practice will not recur, | |

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| | During an interview on 12/6/24 at 2:20 P.M., LPN 9 indicated that all ordered medications and treatments should be documented as completed in the resident's MAR and TAR. When an ordered medication or treatment is not administered or completed, staff should document the reasoning.<br><br>On 12/6/24 at 3:15 P.M., the Facility Administrator supplied an undated facility policy titled Medication Administration General Guidelines. The policy included, "...Documentation (including electronic) 1. The individual who administers the medication dose records the administration on the resident's MAR directly after the medication is given... 6. If a dose of regularly scheduled medication is withheld, refused, not available, or given at a time other than the scheduled time... An explanatory note is entered..."<br><br>3.1-50(a)(1)<br>3.1-50(a)(2) | | i.e., what quality assurance program will be put into place; DON/Designee will perform 5 Medical Record reviews a week for 12 weeks and then 3 times a week for 12 weeks to ensure documentation after Medication/treatment administration is completed, if a dose or medication is withheld, refused, not available or given at a time other than the scheduled time, than an explanatory note is completed.<br><br>**The results of these audits will be reviewed in Quality Assurance Meeting monthly x6 months or until an average of 100 % compliance or greater is achieved x6 consecutive months. The QA Committee will identify any trends or patterns and make recommendations to revise the plan of correction as indicated.** | |
| F 0921 SS=E Bldg. 00 | 483.90(i)<br>Safe/Functional/Sanitary/Comfortable Environ<br><br>Based on observation, interview, and record review, the facility failed to ensure a safe, sanitary, and homelike environment in 2 of 6 resident halls observed. Resident areas had holes in walls, floors appeared dirty and unmopped, bedpans were stored uncovered, cove base was missing from a resident restroom, a vent fan was missing a cover in a resident restroom, used Styrofoam cups were not removed from a resident's room, and resident wheelchairs had not been cleaned. (C/D | F 0921 | what corrective action(s) will be accomplished for those residents found to have been affected by the deficient practice; Resident D's room has been cleaned including throwing away of Styrofoam cups.<br><br>Resident D's restroom light has been repaired. | 12/23/2024 |

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| | Halls, Resident D, Resident F, Room 32, Room 13, Resident H, Resident G, Resident M)<br><br>Finding includes:<br><br>1. During a review of facility grievance forms on 12/4/24 at 1:30 P.M., a concern/complaint form dated 12/1/24 indicated that a family member to a resident in room 13 made staff aware that the resident had not had any housekeeping services in days and had been out of toilet paper for days. Family indicated the room was filthy.<br><br>During a review of resident council minutes on 12/4/24 at 1:40 P.M., a council meeting held 9/25/24 indicated that residents were requesting that their restrooms be deep cleaned better. A council meeting held 11/26/24 indicated a resident was concerned with their commode not being cleaned and their restroom floor not being swept and mopped.<br><br>During an interview on 12/5/24 at 3:30 P.M., Resident H's family member indicated that the resident had gone days without housekeeping services just a few days prior in room 13. The family member indicated that the resident was out of toilet paper and that the waste bin had not been emptied. The resident used a walker to get around that had tennis balls placed on the bottom to help the walker move across the floor. The tennis balls were covered in dust from the floor not being cleaned.<br><br>2. During an observation on 12/4/24 at 3:07 P.M., Resident D had 5 Styrofoam drinking cups on a bedside table, one the cups was dated 12/2/24.<br><br>During an observation on 12/5/24 at 11:05 A.M., Room 32's restroom was observed to have no | | Resident D's bathroom has been cleaned.<br><br>Resident D's wall near the restroom door has been repaired.<br><br>Resident's restrooms have been stocked with toilet paper.<br><br>Resident's restrooms have been cleaned<br><br>Resident H's room has been cleaned<br><br>Resident's with tennis balls on their walkers have been cleaned and/pr replaced.<br><br>Resident F's restroom has been cleaned, cove base in the restroom has been replaced, the bedpan removed, the vent fan cover has been replaced, and the wall next to the sink cleaned.<br><br>Common areas have been cleaned.<br><br>Common area floors have been cleared.<br><br>C Hall wall between the utility closet and room 40 hole has been repaired.<br><br>Resident G's wheelchairs have been cleaned including the cup holder. | |

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| | functioning light. A bedpan was sitting on top of a wheel chair in the restroom uncovered and contained a brown substance. A wet washcloth was lying in the restroom sink. A hole was located near the door to the restroom. During an interview, Resident D indicated that he did not typically go into the restroom and used a bedpan, and that staff used the restroom to wash their hands.<br><br>During an observation on 12/6/24 at 10:35 A.M., Resident D's restroom light was not functioning and a hole remained in the wall near the restroom door.<br><br>3. During an observation on 12/5/24 at 11:10 A.M., Resident F's restroom contained no cove base, a bedpan was uncovered and resting on the back of the commode, the vent fan was missing a cover, toothpaste was on the wall behind the sink, and white splatter marks were on the wall next to the sink.<br><br>During an observation on 12/6/24 at 10:50 A.M., Resident F's restroom had no cove base, a bedpan was resting on the back of the commode uncovered, the vent fan had no cover, and white splatters remained on the wall next to the sink.<br><br>4. During an observation on 12/5/24 at 11:12 A.M., a common area on Hall D appeared to be unmopped with wheelchair markings crossing the floor and a brown drip stain on the floor near a television.<br><br>During an observation on 12/6/24 at 10:40 A.M., a common area on Hall D appeared to be unmopped with wheelchair markings crossing the floor and a brown drip stain on the floor near a television. | | Resident M's wheelchairs have been cleaned.<br><br>Resident G's room has been cleaned.<br><br>Resident M's room has been cleaned.<br><br>Room 32 light was repaired, bedpan was removed, restroom sink cleaned, and hole in the door repaired.<br><br>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<br>All residents have been potential to be affected by this alleged deficient practice.<br>· Housekeeping Supervisor has been educated on the Facility's Housekeeping Policy including cleaning rooms, bathrooms, emptying trash and making beds.<br><br>Housekeeping Supervisor has been educated on ensuring that the residents rooms are stocked with adequate toilet paper.<br><br>Housekeeping staff have been educated on ensuring that resident's restrooms are stocked with toilet paper.<br><br>Housekeeping Staff have been | |

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| | 5. During an observation on 12/5/24 at 11:15 A.M., the wall between a utility closet and room 40 on the C hall had a hole punctured in it.<br><br>During an observation on 12/6/24 at 10:45 A.M., the wall between a utility closet and room 40 on the C hall had a hole punctured in it.<br><br>6. During an interview an observation on 12/6/24 at 2:55 P.M., Resident G and Resident M indicated that their wheelchairs are never cleaned and that housekeeping did not clean their rooms routinely. Resident G and Resident M's wheelchair wheels were covered in dust. Resident G had a cup holder attached to the wheelchair that had old spills inside of it that had not been cleaned.<br><br>During an interview on 12/6/24 at 11:45 A.M., LPN 9 indicated that bedpans should be cleaned when not in use and covered when stored.<br><br>During an interview on 12/6/24 at 1:40 P.M., the Maintenance Director indicated that they are behind on the maintenance work that needs to be completed and that they could use extra maintenance staff, at least temporarily, to catch up with the work needed to be done.<br><br>During an interview on 12/6/24 at 3:15 P.M., the Facility Administrator indicated that night shift should be cleaning resident wheelchairs but that no wheelchair cleaning schedule existed at that time. The Facility Administrator indicated she would make a cleaning schedule for the resident wheelchairs.<br><br>On 12/6/24 at 2:10 P.M., the Facility Administrator supplied an undated C Hallway Daily Cleaning Log. The Facility Administrator indicated that the cleaning log applied to all resident halls, no just | | educated on the Facility's Housekeeping Policy including cleaning rooms, bathrooms, emptying trash and making beds.<br><br>A wheelchair cleaning schedule has been created and implemented.<br><br>Nursing staff have been educated on the New Wheelchair cleaning schedule and bedpan storage<br><br>Maintenance Director, Maintenance staff have been educated on repair of holes in walls in a timely manner., cove base replacement, vent fan cover replacements, functioning lights,<br><br>what measures will be put into place and what systemic changes will be made to ensure that the deficient practice does not recur;<br>· Housekeeping Supervisor has been educated on the Facility's Housekeeping Policy including cleaning rooms, bathrooms, emptying trash and making beds.<br><br>Housekeeping Supervisor has been educated on ensuring that the residents rooms are stocked with adequate toilet paper.<br><br>Housekeeping staff have been educated on ensuring that resident's restrooms are stocked with toilet paper. | |

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| | the C hall. The log included that resident rooms would have the trash collected, toilet cleaned, and floors would be swept and mopped daily.<br><br>This citation relates to complaints IN00448562 and IN00446746.<br><br>3.1-19(a)(4) | | Housekeeping Staff have been educated on the Facility's Housekeeping Policy including cleaning rooms, bathrooms, emptying trash and making beds.<br><br>A wheelchair cleaning schedule has been created and implemented.<br><br>Nursing staff have been educated on the New Wheelchair cleaning schedule.<br><br>Maintenance Director, Maintenance staff have been educated on repair of holes in walls in a timely manner.<br><br>Audits will be completed 5x/week for 12 weeks and then 3x a week for 12 weeks to ensure ongoing compliance<br><br>how the corrective action(s) will be monitored to ensure the deficient practice will not recur, i.e., what quality assurance program will be put into place;<br>Housekeeping Supervisor and or designee will perform 5 observations a week for 12 weeks and then 3x a week for 12 weeks of resident's rooms, bathrooms to assure cleanliness.<br><br>Housekeeping Supervisor/Designee will perform 5 observations a week for 12 weeks | |

| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER | (X2) MULTIPLE CONSTRUCTION | (X3) DATE SURVEY COMPLETED |
|---|---|---|---|
| | 155042 | A. BUILDING 00<br>B. WING | 12/06/2024 |

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

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|---|---|---|---|---|
| | | | and then 3 times a week for 12 weeks of common areas to ensure cleanliness.<br><br>Maintenance Director will perform 5 observations a week for 12 weeks and then 3 times a week for 12 weeks of walls to ensure repair is completed as needed.<br><br>DON/Designee will perform 5 observations a week for 12 weeks and then 3 times a week for 12 weeks of wheelchairs to ensure cleanliness.<br><br>IDT will complete 5 interviews a week for 12 weeks and then 3 times a week for 12 weeks to ensure resident rooms, bathrooms were maintained in a safe, clean and sanitary manner.<br><br>·The results of the above observations, interviews will be reviewed in the Quality Assurance Meeting monthly until 100% compliance is achieved for 6 consecutive months. The QAA Committee will identify any trends or patterns and make recommendations to revise the plan of correction as indicated. | |