| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION | X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER | X2) MULTIPLE CONSTRUCTION | X3) DATE SURVEY COMPLETED |
|---|---|---|---|
| | | A. BUILDING 00<br>B. WING | 04/21/2025 |

| NAME OF PROVIDER OR SUPPLIER | STREET ADDRESS, CITY, STATE, ZIP COD |
|---|---|
| VIVERA SENIOR LIVING OF JEFFERSONVILLE | 2105 HAMBURG PIKE<br>JEFFERSONVILLE, IN 47130 |

| (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 |
|---|---|---|---|---|
| R 0000<br><br>Bldg. 00 | This visit was for the Investigation of Complaint IN00456593.<br><br>Complaint IN00456593 - State deficiency related to the allegations is cited at R0247.<br><br>Survey date: April 21, 2025<br><br>Facility number: 015121<br><br>Residential Census: 105<br><br>This State Residential Finding is cited in accordance with 410 IAC 16.2-5.<br><br>Quality review completed on April 24, 2025. | R 0000 | The submission of this plan of correction does not indicate an admission by Vivera Senior Living of Jeffersonville that the findings and allegations contained herein are an accurate, true representation of the quality of care provided, and living environment provided to the residents of Vivera Senior Living of Jeffersonville. The community hereby maintains it is in substantial compliance with the requirements of participation for Residential Care Facilities. Please accept this plan of correction as the credible allegation of compliance with all state and federal requirements governing the management of this facility. | |
| R 0247<br><br>Bldg. 00 | 410 IAC 16.2-5-4(e)(7)<br>Health Services - Deficiency<br><br>Based on observation, interview and record, the facility failed to ensure a resident (Resident B) received her routine pain medication, as ordered by the physician, for 1 of 3 residents reviewed for Health Services.<br><br>Findings include:<br><br>The clinical record for Resident B was reviewed on 4/21/25 at at 10:29 a.m. The resident's diagnoses included, but were not limited to, rheumatoid arthritis and porphyria. | R 0247 | Plan of Correction<br>05/05/2025<br>Facility ID: 015121<br>Survey Event ID: MZYC11<br>R247<br><br>**1 What corrective action(s) will be accomplished for those residents found to have been affected by the deficient practice;** | 05/15/2025 |

| LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE | TITLE | (X6) DATE |
|---|---|---|
| Jenny Fultz Brown | executive director | 05/02/2025 |

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.

| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION | X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER | X2) MULTIPLE CONSTRUCTION | X3) DATE SURVEY COMPLETED |
|---|---|---|---|
| | | A. BUILDING 00<br>B. WING | 04/21/2025 |

| NAME OF PROVIDER OR SUPPLIER | STREET ADDRESS, CITY, STATE, ZIP COD |
|---|---|
| VIVERA SENIOR LIVING OF JEFFERSONVILLE | 2105 HAMBURG PIKE<br>JEFFERSONVILLE, IN 47130 |

| (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 |
|---|---|---|---|---|
| | The physician's order, dated 10/9/24, indicated the resident was to receive morphine sulfate (narcotic pain medication) 30 mg (milligrams) twice daily at 9:00 a.m. and 9:00 p.m.<br><br>The progress note, dated 3/28/25 at 4:16 p.m., indicated the resident missed her 9:00 a.m. dose of morphine on 3/27/25 with no adverse side effects.<br><br>The March 2025 medication administration record indicated, on 3/27/25 at 9:00 a.m., Licensed Practical Nurse (LPN) 4 administered the medication to the resident.<br><br>Review of the March 2025 controlled drug record lacked documentation of the administration of the morphine on 3/27/25 at 9:00 a.m.<br><br>During an interview, on 4/21/25 at 2:24 p.m., LPN 4 indicated she was going to administer the medication, but could not find it. She looked for liquid morphine rather than pill form as she was unaware the morphine was available in pill form.<br><br>During an interview, on 4/21/25 at 2:27 p.m., the Executive Director (ED) indicated LPN 4 did not reach out to anyone when she could not locate the medication.<br><br>On 4/21/25 at 3:02 p.m., the Executive Director provided a current, undated copy of the document titled "Medication Policy". It included, but was not limited to, "Medicine is to be taken regularly by the resident, as prescribed by his/her physician...."<br><br>This Citation relates to Complaint IN00456593 | | a **2 How the facility will identify other residents having the potential to be affected by the same deficient practice and what corrective action will be taken;**<br><br>a All residents that receive routine pain medications, administered by the facility, had the potential to be affected by the alleged deficient practice. Any employee responsible for passing medications will ensure the residents' physician and the DON are notified when medications are not available. Employees found to be out of compliance with medication distribution will receive additional education and corrective action.<br><br>**3 What measures will be put into place or what systemic changes the facility will make to ensure that the deficient practice does not recur;**<br><br>a DON and/or designee will ensure the residents physician is notified in a timely manner of resident's medication being unavailable. Staff will chart in the electronic medical record, according to policy. In the event a charting error has occurred, an incident report will be completed and reported to the DON and/or designee immediately. Any clinical staff member out of | |

| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER | (X2) MULTIPLE CONSTRUCTION | (X3) DATE SURVEY COMPLETED |
|---|---|---|---|
| | | A. BUILDING 00<br>B. WING | 04/21/2025 |

| NAME OF PROVIDER OR SUPPLIER | STREET ADDRESS, CITY, STATE, ZIP COD |
|---|---|
| VIVERA SENIOR LIVING OF JEFFERSONVILLE | 2105 HAMBURG PIKE<br>JEFFERSONVILLE, IN 47130 |

| (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 |
|---|---|---|---|---|
| | | | compliance with facility's policies and protocols will receive progressive corrective action, including termination. The Director of Nursing, or designee will educate all newly hired clinical staff, including any agency staff, on policies and protocols during employee job-specific orientation moving forward.<br><br>**4 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><br>a This process will be reviewed by ED/DON or designee on a weekly basis for 8 weeks, monthly for 4 months and as needed thereafter as part of the QA process.<br>b Results will be reviewed as part of the QA process in order to identify any anomalies or potential patterns. If indicated, an action plan will be implemented by QA team and reviewed as needed until resolved.<br><br>**5 By what date the systemic changes will be completed;**<br><br>a 05/15/25 | |