

Indiana Department of Health

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 015121	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING _____	(X3) DATE SURVEY COMPLETED R-C 05/21/2025
--	---	---	--

NAME OF PROVIDER OR SUPPLIER VIVERA SENIOR LIVING OF JEFFERSONVILLE	STREET ADDRESS, CITY, STATE, ZIP CODE 2105 HAMBURG PIKE JEFFERSONVILLE, IN 47130
---	--

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (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) COMPLETE DATE
{R 000}	<p>INITIAL COMMENTS</p> <p>This visit was for a Post Survey Revisit (PSR) to Investigation of Complaint IN00456593 completed on 4/21/25.</p> <p>This visit was in conjunction with the PSR to the Investigation of Complaint IN00454400 completed on 3/18/25.</p> <p>Complaint IN00456593 - Corrected</p> <p>Complaint IN00454400 - Corrected</p> <p>Survey date: May 21, 2025</p> <p>Facility number: 015121</p> <p>Residential Census: 107</p> <p>Vivera Senior Living Center was found to be in compliance with 410 IAC 16.2-5 in regard to the PSR to Investigation of Complaint IN00456593.</p> <p>Quality review completed on May 27, 2025.</p>	{R 000}		

Indiana Department of Health LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE	TITLE	(X6) DATE
---	-------	-----------