STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER	X2) MULTIPLE CONSTRUCTION	X3) DATE SURVEY COMPLETED
		A. BUILDING 00 B. WING	03/28/2023

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP COD
VIVERA SENIOR LIVING OF COLUMBUS	1971 STATE STREET COLUMBUS, IN 47201

(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 Bldg. 00	This visit was for the Investigation of Complaint IN00402744 and IN00404112. Complaint IN00402744 - State deficiency related to the allegations is cited at R0027. Complaint IN00404112 - No deficiency related to the allegation is cited. Survey dates: March 27 and 28, 2023 Facility number: 014519 Residential Census: 98 This State Residential Finding is cited in accordance with 410 IAC 16.2-5. Quality review completed on March 30, 2023.	R 0000	Plan of Correction 04/05/23 Facility ID: 014519 Survey Event ID: S5UB11 R027 **What corrective action will be accomplished for those residents found to have been affected by the deficient practice**: a. a. All residents had the potential to be affected by the alleged deficient practice. **What measures will be put into place or what systemic changes the facility will make to ensure that the practice does not recur?** a. Administrator and/or designee will educate all staff on Resident Privacy. All new staff will be educated during their general orientation and job specific orientation. Employees found to be out of compliance with the Resident Privacy Policy will receive additional education and possible corrective action. **How the corrective action will be monitored to ensure the deficient practice will not recure. Grievance and concerns will be discussed at**	

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE	TITLE	(X6) DATE
Dena Johnson	LPN DON	04/07/2023

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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			morning meetings. a. All concerns and/or grievances, regarding resident rights, will be reviewed and action taken immediately. All concerns will be documented and discussed at the monthly QA meeting including any disciplinary action. This practice will be ongoing. **By what date the systemic changes will be completed.** a. April 7, 2023	
R 0027 Bldg. 00	410 IAC 16.2-5-1.2(b) Residents' Rights - Deficiency (b) Residents have the right to a dignified existence, self-determination, and communication with and access to persons and services inside and outside the facility. Residents have the right to exercise their rights as a resident of the facility and as a citizen or resident of the United States. Based on interview and record review, the facility failed to ensure a resident's rights to privacy were not violated when a staff member entered his apartment uninvited and made a visitor leave for 1 of 3 residents reviewed for resident rights. (Resident B) Findings include: During an interview on 3/28/23 at 9:00 a.m., the Director of Nursing (DON) indicated a staff member reported to the second shift Licensed Practical Nurse (LPN) 2 that Resident B's family member was in the chair, sweating, and was passed out. LPN 2 went into the room and shook	R 0027	Plan of Correction 04/05/23 Facility ID: 014519 Survey Event ID: S5UB11 R027 **What corrective action will be accomplished for those residents found to have been affected by the deficient practice**: a. a. All residents had the potential to be affected by the alleged deficient practice.	04/07/2023

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	her, to try and wake her up. The LPN had made the visitor leave. Resident B felt it was unnecessary for staff to make his visitor leave. During an interview on 3/28/23 at 11:02 a.m., LPN 2 indicated a CNA (Certified Nurse Aide) reported to them Resident B's family member was in his room in the recliner, passed out, and slumped over the side of the chair. She did not recall who the CNA was or the date of the incident. She had knocked on the door, was invited in, and told Resident B she was there to check on the female visitor. Resident B was sitting on the side of the bed. Both a male and female visitor were in the recliner, but he got up when she tried to wake the female. Resident B said, "Oh, she was just sleeping." The female was passed out, so she shook her, but did not get a response. She shook the female visitor's shoulder and said "mam, mam." The male visitor told the female to wake up and talk. She told them, "It's late, your asleep, and not visiting. I will give you 5 minutes to leave." LPN 2 told her, she needed to leave, and the male visitor was trying to get her up to leave. She called the police and reported a visitor was under the influence. Resident B asked her what gave her the right to call the police. She informed him it was her responsibility for the safety of all residents. The LPN went back in 5 minutes later and the female visitor was in the bathroom and would not come out, so she stepped out into the hall and called the police. The local police arrived, went to the apartment, knocked, asked her how she was doing, and informed her that the facility was asking her to leave. She picked up her belongings and left. During an interview on 3/28/23 at 11:22 a.m., the DON indicated there were no progress notes related to the incident with Resident B's visitor.		**What measures will be put into place or what systemic changes the facility will make to ensure that the practice does not recur?** a. Administrator and/or designee will educate all staff on Resident Privacy. All new staff will be educated during their general orientation and job specific orientation. Employees found to be out of compliance with the Resident Privacy Policy will receive additional education and possible corrective action. **How the corrective action will be monitored to ensure the deficient practice will not recure. Grievance and concerns will be discussed at morning meetings**. a. All concerns and/or grievances, regarding resident rights, will be reviewed and action taken immediately. All concerns will be documented and discussed at the monthly QA meeting including any disciplinary action. This practice will be ongoing. **By what date the systemic changes will be completed.** a. April 7, 2023	

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	She had contacted the police department but was unable to obtain information because she did not have the date of the incident. During an observation and interview on 3/28/23 at 11:41 a.m., the Business Office Manager (BOM) provided the original lease agreement for Resident B. The current lease, dated 5/4/22, indicated " ...F. Visitors and Guests ...the right to have family members and guest visit your unit at any time ...An overnight guest may stay with you in your Unit ..." The BOM and Admission Coordinator indicated there were no addendums to the original lease or the current lease. During an interview on 3/28/23 at 12:35 p.m., Resident B indicated he had not asked for help the night the staff came into his apartment and made his female visitor leave. He did not know why they came in and did not invite them in. They knocked on the door and just entered the apartment. The current facility policy titled, " Statement of Resident's Rights" with a revision date of 8/28/20, was provided by the DON on 3/27/23 at 10:33 a.m. The Policy indicated, " ...Residents shall be afforded all rights guaranteed under the Constitutions of the United States and the State of Indiana ...Each resident shall have the right to: ...5. Be treated as an individual with consideration and respect for his or her privacy. Privacy shall be afforded for ...visitations ..." This State Findings relates to Complaint IN00402744.			