| 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 | 02/28/2024 |

| NAME OF PROVIDER OR SUPPLIER | STREET ADDRESS, CITY, STATE, ZIP COD |
|---|---|
| VIVERA SENIOR LIVING OF COLUMBUS | 1971 STATE STREET<br>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 |
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| R 0000<br><br>Bldg. 00 | This visit was for the Investigation of Complaint IN00428471.<br><br>Complaint IN00428471 - State deficiency related to the allegation is cited at R0297.<br><br>Survey date: February 28, 2024<br><br>Facility number: 014519<br><br>Residential Census: 95<br><br>This State Residential Finding is cited in accordance with 410 IAC 16.2-5.<br><br>Quality review completed on March 1, 2024. | R 0000 | Submission of this response and Plan of Correction is not a legal admission that a deficiency exists or, that this Statement of Deficiencies was correctly cited, and is also not to be construed as an admission against interest by the facility, or any employees, agents, or other individuals who drafted or may be discussed in the response or Plan of Correction. In addition, preparation and submission of this Plan of Correction does not constitute an admission or agreement by the facility of the truth of any facts alleged or the correctness of any conclusions set forth in this allegation by the survey agency. | |
| R 0297<br><br>Bldg. 00 | 410 IAC 16.2-5-6(c)(1)<br>Pharmaceutical Services - Noncompliance<br><br>Based on observation, interview, and record review, the facility failed to administer medications appropriately for 1 of 4 residents observed for medication administration. (Resident B)<br><br>Findings include:<br><br>During an observation and interview on 02/28/24 at 11:32 A.M., Resident B answered her door in her pajamas. The room was dark, and the resident indicated they had just gotten out of bed. A medication cup with nine pills of various colors and sizes was left sitting on a nearby table. The resident indicated the staff usually brought her | R 0297 | What corrective action(s) will be accomplished for those residents found to have been affected by the deficient practice;<br>An in-service was held by Director of Nursing on 3/7/2024 with all clinical staff about proper medication administration.<br><br>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; | 03/11/2024 |

| LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE | TITLE | (X6) DATE |
|---|---|---|
| Kristen Chalou | Administrator | 03/11/2024 |

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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| | medications to her room between 8:00 A.M. and 9:00 A.M. and left them there for her to take when she got up. She did not know what kind of medications were in the cup.<br><br>The clinical record for Resident B was reviewed on 02/28/24 at 10:40 A.M. The diagnoses included, but were not limited to, diabetes, stroke, and dementia.<br><br>The clinical record lacked a resident self-administration medication assessment.<br><br>The EMAR (Electronic Medication Administration Record) for February 2024 was provided by the DON (Director of Nursing) on 02/28/24 at 2:00 P.M. The record indicated the resident was to receive the following oral medications scheduled at 8:00 A.M.:<br><br>- Clopidogrel 75 mg (milligrams),<br>- Lasix 40 mg,<br>- Losartan 25 mg,<br>- Memantine 10 mg,<br>- Myrbetriq 50 mg,<br>- Pioglitazone 15 mg,<br>- Solifenacin 5 mg,<br>- Topiramate 50 mg, and<br>- Venlafaxine 150 mg.<br><br>During an interview on 02/28/24 at 12:22 P.M., QMA (Qualified Medication Aide) 2 indicated, when a resident was admitted to the facility, the staff would complete an assessment to determine if the resident was capable of self-administering their medications. All residents whose medications were administered by staff were on the EMAR. The EMAR for Resident B was observed and had blue checks indicating the resident had received her morning oral | | All residents had the potential to be affected.<br><br>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>Director of Nursing or designee will conduct audits consisting of observation of medication administration by QMA's and LPN's.<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>Director of Nursing will complete audits as follows:<br>-5 med pass observations daily Monday – Friday x's 2 weeks<br>-3 med pass observations daily Monday – Friday x's 2 weeks<br>-2 med pass observations daily Monday – Friday x's 2 weeks<br>-1 med pass observation daily Monday – Friday x's 2 weeks<br><br>By what date the systemic changes will be completed.<br>- 3/11/24 | |

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| | medications, but had refuse her insulin.<br><br>During an interview on 02/28/24 at 1:19 P.M., QMA 4 indicated when passing medications, the staff were required to stay with the resident until they consumed their medications. Staff administered all of Resident B's medications and were not to leave medications at the bedside for the residents who did not self-administer their medications.<br><br>The current "Medication Management, Administration, & Storage" policy, with a revised date of 01/2024, was provided by the DON on 02/28/24 at 2:00 P.M. The policy indicated, "...The purpose of this policy is to ensure that resident safety is maintained when managing, preparing, administering...all medications while complying with state and federal guidelines...If a resident is assessed as Needing Assistance with Medication Administration, it is the responsibility of the licensed nurse or Qualified Medication Aide...to administer the medications to the resident...Documentation: At the time of administration, the licensed nurse or QMA administering the medication will document the administration in the medication...administration record that includes the following:...Date, Time..."<br><br>This citation relates to Complaint IN00428471. | | | |