STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTIONS	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
		A. BUILDING B. WING	07/14/2021

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES...	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION...	(X5) COMPLETION DATE
R 0000	INITIAL COMMENTS This visit was for the Investigation of Complaints IN00357822 and IN00356918. Complaint IN00357822 - Substantiated. State Residential Findings related to the allegations are cited at R0297. Complaint IN00356918 - Substantiated. State Residential Findings related to the allegations are cited at R0297. Survey date: July 14, 2021. Facility number: 014519 Residential Census: 66 These State Residential Findings are cited in accordance with 410 IAC 16.2-5. Quality review completed on July 21, 2021.	R 0000	Resident E's Lyrica medication was obtained on July 12, 2021. 2.Residents receiving medication administration have potential to be affected by this alleged deficient practice. Resident's medications were audited that are receiving medication administration, physicians and pharmacy were contacted and medication obtained if not available for administration. 3.Director of Nursing inserviced nurses on July 15, 2021 on pharmacy services for refills and obtaining a Narcotic script in timely manner to ensure residents medications are available for administration. 4.Director of Nursing and/or designee will audit medication documentation daily x 4 weeks, then weekly x 3 months, then monthly x 3 months to ensure medications are available and/or in process of obtaining medication in a timely manner. Medication audits will be	

			reviewed at the quarterly QA meetings, QA committee will make recommendations for need of ongoing audits. 5.Compliance date August 14, 2021	
R 0297	Pharmaceutical Services - Noncompliance 410 IAC 16.2-5-6(c)(1) (c) If the facility controls, handles, and administers medications for a resident, the facility shall do the following for that resident: (1) Make arrangements to ensure that pharmaceutical services are available to provide residents with prescribed medications in accordance with applicable laws of Indiana. Based on observation, interview, and record review, the facility failed to provide a resident with prescribed medications in a timely manner for 1 of 5 residents reviewed. (Resident E) Findings include: During an observation and interview on 07/14/21 at 11:19 A.M., Resident E indicated she had not received her prescribed Lyrica, a pain medication, for a few days. QMA (Qualified Medication Aide) 2 was administering the resident's	R 0297	1. Resident E's Lyrica medication was obtained on July 12, 2021. 2. Residents receiving medication administration have potential to be affected by this alleged deficient practice. Resident's medications were audited that are receiving medication administration, physicians and pharmacy were contacted and medication obtained if not available for administration. 3. Director of Nursing inserviced nurses on July 26, 2021 on pharmacy services for refills and obtaining a Narcotic script in timely manner to ensure residents medications are available for administration.	08/14/2021

	medications during the observation. During an interview on 07/14/21 at 11:21 A.M., QMA 2 indicated the resident had taken her last dose of Lyrica on Friday, 07/09/21. The medication reorder was faxed to the pharmacy on 07/09/21. The pharmacy was closed on the weekend and staff were unaware the resident needed a new prescription which caused a delay in receiving the medication. The clinical record was reviewed on 07/14/21 at 12:00 P.M. The resident was alert and oriented. Diagnoses included, but were not limited to, hypertension, cardio myopathy, and chest pain. An open ended physician's order, with a start date of 10/05/20, indicated the resident was to receive Lyrica (a nerve pain medication), 200 milligrams, three times a day, at 8:00 A.M., 12:00 P.M., and 6:00 P.M. The EMAR (Electronic Medication Administration Record) for July 2021, was provided by the DON (Director of Nursing) on 07/14/21 at 1:45 P.M. The record indicated the resident had not received her prescribed Lyrica pain medication on the following		4. Director of Nursing and/or designee will audit medication documentation daily x 4 weeks, then weekly x 3 months, then monthly x 3 months to ensure medications are available and/or in process of obtaining medication in a timely manner. Medication audits will be reviewed at the quarterly QA meetings, QA committee will make recommendations for need of ongoing audits. 5. Compliance date August 14, 2021	

dates and times:

- 07/11/21 at 8:00 A.M., 12:00 P.M., and 6:00 P.M.,

- 07/12/21 at 12:00 P.M. and 6:00 P.M., and

- 07/13/21 at 8:00 A.M.

During an interview on 07/14/21 at 12:03 P.M., the DON indicated the residents' medications should be refilled when they were down to a remaining 5 day supply.

The current "EXTENDED PHARMACY SERVICE GUIDE", dated 11/19/19, was provided by the DON on 07/14/21 at 11:52 A.M. The policy indicated, " ...PHARMACY ORDER ...fax these 5 days before scheduled cycle data ...Refill stickers and request ..."

This State deficiency is related to Complaints IN00357822 and IN00356918.

Based on observation, interview, and record review, the facility failed to provide a resident with prescribed medications in a timely manner for 1 of 5 residents reviewed. (Resident E)

Findings include:

During an observation and interview on 07/14/21 at 11:19

A.M., Resident E indicated she had not received her prescribed Lyrica, a pain medication, for a few days. QMA (Qualified Medication Aide) 2 was administering the resident's medications during the observation.

During an interview on 07/14/21 at 11:21 A.M., QMA 2 indicated the resident had taken her last dose of Lyrica on Friday, 07/09/21. The medication reorder was faxed to the pharmacy on 07/09/21. The pharmacy was closed on the weekend and staff were unaware the resident needed a new prescription which caused a delay in receiving the medication.

The clinical record was reviewed on 07/14/21 at 12:00 P.M. The resident was alert and oriented. Diagnoses included, but were not limited to, hypertension, cardio myopathy, and chest pain.

An open ended physician's order, with a start date of 10/05/20, indicated the resident was to receive Lyrica (a nerve pain medication), 200 milligrams, three times a day, at 8:00 A.M., 12:00 P.M., and 6:00 P.M.

The EMAR (Electronic Medication Administration Record) for July 2021, was

provided by the DON (Director of Nursing) on 07/14/21 at 1:45 P.M. The record indicated the resident had not received her prescribed Lyrica pain medication on the following dates and times:

- 07/11/21 at 8:00 A.M., 12:00 P.M., and 6:00 P.M.,

- 07/12/21 at 12:00 P.M. and 6:00 P.M., and

- 07/13/21 at 8:00 A.M.

During an interview on 07/14/21 at 12:03 P.M., the DON indicated the residents' medications should be refilled when they were down to a remaining 5 day supply.

The current "EXTENDED PHARMACY SERVICE GUIDE", dated 11/19/19, was provided by the DON on 07/14/21 at 11:52 A.M. The policy indicated, " ...PHARMACY ORDER ...fax these 5 days before scheduled cycle data ...Refill stickers and request ..."

This State deficiency is related to Complaints IN00357822 and IN00356918.

Any deficiency statement ending with an asterisk (*) denotes a deficiency which the institution may be excused from correcting provided it is determined that other safeguards provide sufficient protection to the patients. (See instructions.)

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE	TITLE	(X6) DATE