STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTIONS	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
		A. BUILDING B. WING	07/14/2022

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 a State Residential Licensure Survey. Survey dates: July 13 and 14, 2022 Facility number: 014519 Residential Census: 101 These State Residential Findings are cited in accordance with 410 IAC 16.2-5. Quality review completed on July 21, 2022.	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 0092	Administration and Management - Noncompliance 410 IAC 16.2-5-1.3(i)(1-2)	R 0092	It is the practice of Vivera Senior Living to ensure fire drills are completed monthly and on rotating shifts to ensure all	08/12/2022

	(i) The facility must maintain a written fire and disaster preparedness plan to assure continuity of care of residents in cases of emergency as follows: (1) Fire exit drills in facilities shall include the transmission of a fire alarm signal and simulation of emergency fire conditions, except that the movement of nonambulatory residents to safe areas or to the exterior of the building is not required. Drills shall be conducted quarterly on each shift to familiarize all facility personnel with signals and emergency action required under varied conditions. At least twelve (12) drills shall be held every year. When drills are conducted between 9 p.m. and 6 a.m., a coded announcement may be used instead of audible alarms. (2) At least every six (6) months, a facility shall attempt to hold the fire and disaster drill in conjunction with the local fire department. A record of all training and drills shall be documented with the names and signatures of the personnel present. Based on record review and interview the facility failed to regularly conduct fire drills for 10 of the 12 months reviewed. Findings include: The fire drills records were provided by the Administrator on 07/13/22 at 11:45 A.M. The records lacked documentation		staff are participating. **What corrective action will be accomplished for those residents found to have been affected by the deficient practice?** A fire drill was conducted on July 22, 2022, on third shift. Fire drills were conducted on August 4, 2022, on both first and second shifts. **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?** A fire drill was conducted on July 22, 2022, on third shift. Fire drills were conducted on August 4, 2022, on both first and second shifts. **What measures will be put into place or what systemic changes the facility will make to ensure that the practice does not recur?** Fire drills will be conducted	

	to indicate the required fire drills were conducted for the following months: - July 2021, - August 2021, - September 2021, - October 2021, - November 2021, - December 2021, - January 2022, - February 2022, - March 2022, and - April 2022. During an interview on 07/13/22 at 12:00 P.M., the Administrator indicated he only had fire drills for the months of May and June 2022. Fire drills should have been completed once a month, alternating shifts each month. During an interview on 07/14/22 at 10:14 A.M., the Administrator indicated after being here for several months, when providing safety education, he noticed fire drills were not being conducted per the guidelines. The current undated Fire Drill Simulation policy was provided by the Administrator on 07/13/22 at 12:15 P.M. The		monthly with a rotation of times between all shifts, so every shift will have a fire drill at least quarterly. The Maintenance Director was educated on the expectation of monthly and rotating fire drills. All staff were educated on the monthly and rotating drills. **How the corrective action(s) will be monitored to ensure the deficient practice will not recure, i.e. what quality assurance program will be put into place?** A quality assurance monitoring tool will be completed by Administrator/designee. Fire drills occurring monthly and rotating covering all shifts quarterly and accompanying documentation will be verified on the tool. This will be completed daily times four weeks and then weekly times one month. At this time if results are below a 95% threshold the audits will continue weekly until a 95% threshold is achieved. The results will be reviewed by the Quality Assurance Process Improvement committee monthly.	

	policy indicated "...Drills will be conducted at random times throughout the year in accordance to facility policy. At a minimum drills will be conducted at least once per shift per quarter..." Based on record review and interview the facility failed to regularly conduct fire drills for 10 of the 12 months reviewed. Findings include: The fire drills records were provided by the Administrator on 07/13/22 at 11:45 A.M. The records lacked documentation to indicate the required fire drills were conducted for the following months: - July 2021, - August 2021, - September 2021, - October 2021, - November 2021, - December 2021, - January 2022, - February 2022, - March 2022, and - April 2022. During an interview on 07/13/22 at 12:00 P.M., the Administrator		**By what date the systemic changes will be completed?** August 12, 2022	

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R 0117	Personnel - Deficiency 410 IAC 16.2-5-1.4(b) (b) Staff shall be sufficient in number, qualifications, and training in accordance with applicable state laws and rules to meet the twenty-four (24) hour scheduled and unscheduled needs of the residents and services provided. The number, qualifications, and training of staff shall depend on skills required to provide for the specific needs of the residents. A minimum of one (1) awake staff person, with current CPR and first aid certificates, shall be on site at	R 0117	It is the practice of Vivera Senior Living to ensure a CPR certified staff member is working at all time. **What corrective action will be accomplished for those residents found to have been affected by the deficient practice?** A daily review of the schedule will be conducted to ensure	08/12/2022

	all times. If fifty (50) or more residents of the facility regularly receive residential nursing services or administration of medication, or both, at least one (1) nursing staff person shall be on site at all times. Residential facilities with over one hundred (100) residents regularly receiving residential nursing services or administration of medication, or both, shall have at least one (1) additional nursing staff person awake and on duty at all times for every additional fifty (50) residents. Personnel shall be assigned only those duties for which they are trained to perform. Employee duties shall conform with written job descriptions. Based on record review and interview the facility failed to schedule a staff member who was certified in Cardiopulmonary Resuscitation (CPR) for 7 of 14 days reviewed. (July 06 through July 12, 2022) Findings include: The employee files were provided by the Administrator and reviewed on 07/14/22 at 9:15 A.M. The following time frames lacked a CPR certified staff member during the review period of 07/06/22 through 07/12/22: - 07/06/22 approximately 5:00 P.M. to 10:00 P.M.,		that a CPR certified individual is working as all times. **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?** A daily review of the schedule will be conducted to ensure that a CPR certified individual is working as all times. **What measures will be put into place or what systemic changes the facility will make to ensure that the practice does not recur?** CPR certification class was held on August 4, 2022, and another scheduled for August 11, 2022. All staff were in-serviced about the need for a CPR certified individual working at all times. **How the corrective action(s) will be monitored to ensure the deficient practice will not recure, i.e. what quality assurance program will be put into place?**	

	- 07/07/22 approximately 5:00 P.M. to 10:00 P.M. and 10:00 P.M. to 6:00 A.M., - 07/08/22 approximately 5:00 P.M. to 10:00 P.M. and 10:00 P.M. to 6:00 A.M., - 07/09/22 6:00 A.M. to 10:00 P.M., - 07/10/22 6:00 A.M. to 10:00 P.M., - 07/11/22 approximately 5:00 P.M. to 10:00 P.M., and - 07/12/22 approximately 5:00 P.M. to 10:00 P.M. During an interview on 07/14/22 at 1:33 P.M., the DON (Director of Nursing) indicated the facility should have a staff member that was CPR certified in the building at all times. The current facility policy titled, "CPR Certifications", and last approved 6/20/22, was provided by the DON on 07/14/22 at 1:41 P.M. The policy indicated, " ...The purpose of this policy is to provide requirements of employee CPR Training ...It is the Director of Nursing's responsibility to ensure at least one employee with a current CPR certification is on duty at all times..." Based on record review and interview the facility failed to schedule a staff member who		A quality assurance monitoring tool will be completed by Administrator/designee. The tool will verify a CPR certified individual is working at all times. This will be completed daily times four weeks and then weekly times one month. At this time if results are below a 95% threshold the audits will continue weekly until a 95% threshold is achieved. The results will be reviewed by the Quality Assurance Process Improvement committee monthly. **By what date the systemic changes will be completed?** August 12, 2022	

	was certified in Cardiopulmonary Resuscitation (CPR) for 7 of 14 days reviewed. (July 06 through July 12, 2022) Findings include: The employee files were provided by the Administrator and reviewed on 07/14/22 at 9:15 A.M. The following time frames lacked a CPR certified staff member during the review period of 07/06/22 through 07/12/22: - 07/06/22 approximately 5:00 P.M. to 10:00 P.M., - 07/07/22 approximately 5:00 P.M. to 10:00 P.M. and 10:00 P.M. to 6:00 A.M., - 07/08/22 approximately 5:00 P.M. to 10:00 P.M. and 10:00 P.M. to 6:00 A.M., - 07/09/22 6:00 A.M. to 10:00 P.M., - 07/10/22 6:00 A.M. to 10:00 P.M., - 07/11/22 approximately 5:00 P.M. to 10:00 P.M., and - 07/12/22 approximately 5:00 P.M. to 10:00 P.M. During an interview on 07/14/22 at 1:33 P.M., the DON (Director			

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R 0120	Personnel - Noncompliance 410 IAC 16.2-5-1.4(e)(1-3) (e) There shall be an organized inservice education and training program planned in advance for all personnel in all departments at least annually. Training shall include, but is not limited to, residents' rights, prevention and control of infection, fire prevention, safety, accident prevention, the needs of specialized populations served, medication administration, and nursing care, when appropriate, as follows: (1) The frequency and content of inservice education and training programs shall be in accordance with the skills and knowledge of the facility personnel. For nursing personnel, this shall include at least eight (8) hours of inservice	R 0120	It is the practice of Vivera Senior Living to ensure all employee files are complete. **What corrective action will be accomplished for those residents found to have been affected by the deficient practice?** The missing items from CNA 2, LPN 3, HSK 4, QMA 5 and DA 6 were completed and added to their employee file. **How the facility will identify other residents having the potential to be affected by the same deficient practice and**	08/12/2022

per calendar year and four (4) hours of inservice per calendar year for nonnursing personnel.

(2) In addition to the above required inservice hours, staff who have contact with residents shall have a minimum of six (6) hours of dementia-specific training within six (6) months and three (3) hours annually thereafter to meet the needs or preferences, or both, of cognitively impaired residents effectively and to gain understanding of the current standards of care for residents with dementia.

(3) Inservice records shall be maintained and shall indicate the following:

(A) The time, date, and location.

(B) The name of the instructor.

(C) The title of the instructor.

(D) The names of the participants.

(E) The program content of inservice.

The employee will acknowledge attendance by written signature.

Based on record review and interview, the facility failed to maintain current employee records related to orientation and references for 5 of 5 employee records reviewed. (CNA 2, LPN 3, HSK 4, QMA 5, and DA 6)

what corrective action will be taken?

An audit was conducted on all remaining employee files. Missing items were completed and placed in the employee file.

What measures will be put into place or what systemic changes the facility will make to ensure that the practice does not recur?

The Business Office Manager was in-serviced on the requirement of complete employee files. All staff were in-serviced about the need complete files.

How the corrective action(s) will be monitored to ensure the deficient practice will not recure, i.e. what quality assurance program will be put into place?

A quality assurance monitoring tool will be completed by Administrator/designee. The tool will verify employee files include all required documents. This will be completed daily times four weeks and then weekly times one month. At this

Findings include:

The employee records were provided by the Administrator on 07/14/22 at 9:15 A.M. The records lacked required information for the following employees:

- CNA (Certified Nurse Aide) 2: Specific Job Orientation,

- LPN (Licensed Practical Nurse) 3: General and Specific Job Orientation,

- HSK (Housekeeper) 4: References and Specific Job Orientation,

- QMA (Qualified Medication Aide) 5: References, and

- DA (Dietary Aide) 6: General Orientation.

During an interview on 07/14/22 at 10:46 A.M., the BOM (Business Office Manager) indicated the employee records should contain the required employee references and orientation.

The current Personnel Records policy, with an effective date of 01/06/22, was provided by the BOM on 07/14/22 at 11:24 A.M. The policy indicated, "...One person will be given responsibility for maintaining Employee records and for filling Employee-related documents...Upon employment,

time if results are below a 95% threshold the
audits will continue weekly until a 95% threshold is achieved. The results will
be reviewed by the Quality Assurance Process Improvement committee monthly.

By what date the systemic changes will be completed?

August 12, 2022

a personnel file will be established. The Administrator or his/her designee will assure that all documents are signed prior to but no later than the completion of the person's first day of employment...The following documents will be retained in the personnel file or separate file as appropriate...Reference inquiry...Orientation checklist..."

Based on record review and interview, the facility failed to maintain current employee records related to orientation and references for 5 of 5 employee records reviewed. (CNA 2, LPN 3, HSK 4, QMA 5, and DA 6)

Findings include:

The employee records were provided by the Administrator on 07/14/22 at 9:15 A.M. The records lacked required information for the following employees:

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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