STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTIONS	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
		A. BUILDING B. WING	10/28/2021

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 IN00365083, IN00364961, IN00364965, and IN00364993. Complaint IN00365083 - Substantiated with no deficiencies cited. Complaint IN00364961 - Unsubstantiated due to lack of evidence. Complaint IN00364965 - Unsubstantiated due to lack of evidence. Complaint IN00364993 - Substantiated. State deficiencies related to the allegations are cited at R0241. Survey date: October 27 and 28, 2021 Facility number: 014519 Residential Census: 92 These State Residential Findings are cited in accordance	R 0000		

	with 410 IAC 16.2-5. Quality review completed on October 29, 2021			
R 0241	Health Services - Offense 410 IAC 16.2-5-4(e)(1) (e) The administration of medications and the provision of residential nursing care shall be as ordered by the resident ' s physician and shall be supervised by a licensed nurse on the premises or on call as follows: (1) Medication shall be administered by licensed nursing personnel or qualified medication aides. Based on observation, interview, and record review, the facility failed to provide medication to a resident for 1 of 3 residents reviewed for facility administered medications. (Resident C) Findings include: During an observation and interview on 10/28/21 at 9:40 A.M., Resident C was in the main lobby sitting in his motorized chair. He indicated he had a doctor's appointment that morning and was waiting for transportation. He went to dialysis in the morning and had to leave the facility at 2:45 A.M., on Monday, Wednesday, and	R 0241	Plan of Correction 11/10/2021 Facility ID: 014519 Survey Event ID: RGH011 **1. Describe what the facility did to correct the deficient practice for each client cited in the deficiency.** a. Resident C experienced no adverse effects from the alleged deficient practice. **1. Describe how the facility reviewed all clients in the facility that could be affected by the same deficient practice, and state, what actions the facility took to correct the deficient practice for any client the facility identified as being affected.**	11/10/2021

	Friday. There were several times when he did not get his insulin before he left for dialysis. Staff would tell him there was not a nurse on duty to administer the insulin. The staff did not give him his insulin when he came back from dialysis. He usually got back from dialysis around 11:00 A.M. The nurses during the night came from the agency. He would get his other medications in the morning before he left for dialysis. He was normally in his room at 8:00 A.M., when his insulin was due. If he wasn't, the staff would go to the dining room and take him back to administer the insulin. The clinical record was reviewed on 10/27/21 at 3:30 P.M. A "SELF ADMINISTRATION MEDICATION ASSESSMENT", dated 07/30/21, indicated the resident preferred the nursing staff to administer his medications. Diagnoses included, but were not limited to, end stage renal disease, diabetes, and hypertension. The resident was not cognitively impaired. The EMAR (Electronic Medication Administration Record) was provided by the DON (Director of Nursing) on 10/27/21 at 12:20 P.M. The record indicated the resident was to receive Basaglar insulin injection, 15 units,		a. All residents requiring assistance with medication administration, by the facility, had the potential to be affected by the alleged deficient practice. Administrator and DON in-serviced clinical staff, including agency staff, on procedures of medication administration and proper documentation on 10/28/2021. Interim DON audited eMAR and had the staff address unattended medications from 10/1/2021 to 10/31/2021. Employees found to be out of compliance with medication documentation will receive additional education and corrective action. **1. Describe the steps or systemic changes the facility has made or will make to ensure that the deficient practice does not recur, including any in-services, but this also should include any system changes you made.** a. All clinical staff, including agency staff, will be re-educated and in-serviced on medication administration and	

	subcutaneously, daily at 8:00 A.M. The record was left blank on Saturday, 10/09/21, and on Sunday, 10/24/21. The Clinical Notes were provided by the DON on 10/28/21 at 11:20 A.M. A note, dated 10/14/21 at 1:08 P.M., indicated the resident's medication was a day off and staff had called the pharmacy to request a day supply to prevent the resident from any delay in medication. During an interview on 10/28/21 at 11:00 A.M., LPN (Licensed Practical Nurse) 2 indicated when a QMA (Qualified Medication Aide) was passing medications, the nurse on duty would provide insulin for the diabetic residents. Anything the QMA was not qualified to do, the nurse on duty would take care of. Resident C left the facility for dialysis. On dialysis days the night shift nurse would administer his medications and insulin. On dialysis days she did not normally give him his morning medications. Sometimes it could be a nurse or a QMA working the night shift. On the spaces that were left blank on the 9th and 24th, of October, the nurse either forgot to check off that the medications were administered, or it did not get completed as ordered. During an interview on 10/28/21		documentation no later than December 1, 2021. Any clinical staff member out of compliance with facility's policies and protocols relating to medication administration and documentation will receive progressive correxitve action, including termination. The Director of Nursing, or designee will educate all newly hired clinical staff, including agency staff, on policies and protocols relating to medication administration and documentation during employee job-specific orientation moving forward. **Please explain how the facility will ensure residents will receive their medications when an altered schedule is needed for appointments** The Director of Nursing or designee will determine if medication administration times can be altered based on appointment times and verified with physician. Facility will ensure medication will be given as prescribed.**1.**	

	at 11:09 A.M., the DON indicated on the days the resident went to dialysis he did not get his insulin if a QMA was on duty. He went to dialysis so early that he was in the time frame to get his insulin when he got back from dialysis. She had never been here when he had gone to dialysis. Staff were supposed to document on the EMAR when they gave a medication. There should never be a blank on an EMAR. The current undated "INDIANA MEDICATION OVERSIGHT, ADMINISTRATION, STORAGE" policy was provided by the DON on 10/28/21 at 11:20 A.M. The policy indicated, " ...The community shall have available on the premises or on call the services of a licensed nurse at all times ...If a resident is assessed as needing medication administration, it is the responsibility of the licensed nursing personnel or qualified medication aide to administer the medications to the resident ...It is the responsibility of the Nursing Supervisor and/or Staff Nurse to administer all injectable medications ...The individual administering the medication shall document the administration in the electronic medication (or treatment) administration record ..."		**1.Describe how the corrective action(s) will be monitored to ensure the deficient practice will not recur (ie what quality assurance program will be put into place)** a. The Director of Nursing or designee will audit the eMAR five (5) times per week for eight (8) weeks, then three (3) times a week for four (4) weeks, then two (2) times a week for four (4) weeks and then weekly for eight (8) weeks, then as needed to ensure that proper medication administration and documentation is being executed. Results to be reviewed at monthly QI meetings and make further recommendations based off audit results	

	This State tag relates to Complaint IN00364993. Based on observation, interview, and record review, the facility failed to provide medication to a resident for 1 of 3 residents reviewed for facility administered medications. (Resident C) Findings include:			

During an observation and interview on 10/28/21 at 9:40 A.M., Resident C was in the main lobby sitting in his motorized chair. He indicated he had a doctor's appointment that morning and was waiting for transportation. He went to dialysis in the morning and had to leave the facility at 2:45 A.M., on Monday, Wednesday, and Friday. There were several times when he did not get his insulin before he left for dialysis. Staff would tell him there was not a nurse on duty to administer the insulin. The staff did not give him his insulin when he came back from dialysis. He usually got back from dialysis around 11:00 A.M. The nurses during the night came from the agency. He would get his other medications in the morning before he left for dialysis. He was normally in his room at 8:00 A.M., when his insulin was due. If he wasn't, the staff would go to the dining room and take him back to administer the insulin.

The clinical record was reviewed on 10/27/21 at 3:30 P.M. A "SELF ADMINISTRATION MEDICATION ASSESSMENT", dated 07/30/21, indicated the resident preferred the nursing staff to administer his medications. Diagnoses included, but were not limited to, end stage renal disease, diabetes, and hypertension. The

resident was not cognitively impaired.

The EMAR (Electronic Medication Administration Record) was provided by the DON (Director of Nursing) on 10/27/21 at 12:20 P.M. The record indicated the resident was to receive Basaglar insulin injection, 15 units, subcutaneously, daily at 8:00 A.M. The record was left blank on Saturday, 10/09/21, and on Sunday, 10/24/21.

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morning medications. Sometimes it could be a nurse or a QMA working the night shift. On the spaces that were left blank on the 9th and 24th, of October, the nurse either forgot to check off that the medications were administered, or it did not get completed as ordered.

During an interview on 10/28/21 at 11:09 A.M., the DON indicated on the days the resident went to dialysis he did not get his insulin if a QMA was on duty. He went to dialysis so early that he was in the time frame to get his insulin when he got back from dialysis. She had never been here when he had gone to dialysis. Staff were supposed to document on the EMAR when they gave a medication. There should never be a blank on an EMAR.

The current undated "INDIANA MEDICATION OVERSIGHT, ADMINISTRATION, STORAGE" policy was provided by the DON on 10/28/21 at 11:20 A.M. The policy indicated, " ...The community shall have available on the premises or on call the services of a licensed nurse at all times ...If a resident is assessed as needing medication administration, it is the responsibility of the licensed nursing personnel or qualified medication aide to administer the medications to the resident ...It is the responsibility of the

	Nursing Supervisor and/or Staff Nurse to administer all injectable medications ...The individual administering the medication shall document the administration in the electronic medication (or treatment) administration record ..." This State tag relates to Complaint IN00364993.			

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