

DEPARTMENT OF HEALTH AND HUMAN SERVICES
CENTERS FOR MEDICARE & MEDICAID SERVICES

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTIONS		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		(X2) MULTIPLE CONSTRUCTION A. BUILDING B. WING		(X3) DATE SURVEY COMPLETED 02/28/2024	
NAME OF PROVIDER OR SUPPLIER VIVERA SENIOR LIVING OF COLUMBUS		STREET ADDRESS, CITY, STATE, ZIP CODE 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 Complaint IN00428471. Complaint IN00428471 - State deficiency related to the allegation is cited at R0297. Survey date: February 28, 2024 Facility number: 014519 Residential Census: 95 This State Residential Finding is cited in accordance with 410 IAC 16.2-5. 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	Pharmaceutical Services - Noncompliance 410 IAC 16.2-5-6(c)(1)	R 0297	What corrective action(s) will be accomplished for those residents found to have been affected	03/11/2024			

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(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 administer medications appropriately for 1 of 4 residents observed for medication administration. (Resident B)

Findings include:

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 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.

The clinical record for Resident B was reviewed on 02/28/24 at 10:40 A.M. The diagnoses

by the deficient practice;

An in-service was held by Director of Nursing on 3/7/2024 with all clinical staff about proper medication administration.

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;

All residents had the potential to be affected.

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

Director of Nursing or designee will conduct audits consisting of observation of medication administration by QMA's and LPN's.

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included, but were not limited to, diabetes, stroke, and dementia.

The clinical record lacked a resident self-administration medication assessment.

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.:

- Clopidogrel 75 mg (milligrams),
- Lasix 40 mg,
- Losartan 25 mg,
- Memantine 10 mg,
- Myrbetriq 50 mg,
- Pioglitazone 15 mg,
- Solifenacin 5 mg,
- Topiramate 50 mg, and
- Venlafaxine 150 mg.

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

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;

Director of Nursing will complete audits as follows:

- 5 med pass observations daily Monday – Friday x's 2 weeks
- 3 med pass observations daily Monday – Friday x's 2 weeks
- 2 med pass observations daily Monday – Friday x's 2 weeks
- 1 med pass observation daily Monday – Friday x's 2 weeks

By what date the systemic changes will be completed.

- 3/11/24

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 medications, but had refuse her insulin.

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.

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..."

This citation relates to Complaint IN00428471.

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)

Findings include:

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 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.

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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	