

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 03/18/2025	
NAME OF PROVIDER OR SUPPLIER VIVERA SENIOR LIVING OF JEFFERSONVILLE		STREET ADDRESS, CITY, STATE, ZIP CODE 2105 HAMBURG PIKE, JEFFERSONVILLE, , 47130					
(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 is for the Investigation of Complaint IN00454400. Complaint IN00454400 - State Residential Deficiencies related to the allegations are cited at R0030, R0039, R0045, R0048, and R0349. Survey Date: March 18, 2025 Facility Number: 015121 Census: 101 These State Residential Findings are cited in accordance with 410 IAC 16.2-5. Quality review completed on March 24, 2025.	R 0000	The submission of this plan of correction does not indicate an admission by Vivera Senior Living of Jeffersonville that the findings and allegations contained herein are an accurate, true representation of the quality of care provided, and living environment provided to the residents of Vivera Senior Living of Jeffersonville. The community hereby maintains it is in substantial compliance with the requirements of participation for Residential Care Facilities. Please accept this plan of correction as the credible allegation of compliance with all state and federal requirements governing the management of this facility.				
R 0030	Residents' Rights - Noncompliance 410 IAC 16.2-5-1.2(e)(1-6)	R 0030	It is the policy of Vivera of Jeffersonville		04/30/2025		

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

	(e) Residents have the right to be provided, at the time of admission to the facility, the following: (1) A copy of his or her admission agreement. (2) A written notice of the facility ' s basic daily or monthly rates. (3) A written statement of all facility services (including those offered on an as needed basis). (4) Information on related charges, admission, readmission, and discharge policies of the facility. (5) The facility ' s policy on voluntary termination of the admission agreement by the resident, including the disposition of any entrance fees or deposits paid on admission. The admission agreement shall include at least those items provided for in IC 12-10-15-9. (6) If the facility is required to submit an Alzheimer ' s and dementia special care unit disclosure form under IC 12-10-5.5, a copy of the completed Alzheimer ' s and dementia special care unit disclosure form. 2. The Communication note with Resident G's family, dated 1/10/25 at 12:15 p.m., indicated staff notified the family member of Resident G's death. The family member wished to contact the rest of the family. The funeral home was contacted per the resident's		to comply with the admission agreement that was agreed upon both the resident and the community prior to move in, including the electric scooter nonrefundable deposit fee. Resident C signed a lease between the resident and the community which showed a nonrefundable deposit for motorized wheelchair/cart. The Executive Director gave copy of the resident's lease to resident, highlighting the area in question. Exhibit wheelchair nonrefundable deposit . Each new move in receives & reviews a copy of the lease upon admission. The signature page acknowledging terms in the lease which includes a list of fees and deposits. All residents receive a copy of the lease for review, prior to signing. The residents will have the opportunity to ask questions regarding the leases and any fees. The Executive Director or designee reviews each new	
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DEPARTMENT OF HEALTH AND HUMAN SERVICES
CENTERS FOR MEDICARE & MEDICAID SERVICES

wishes. The funeral home arrived to transport the resident's body.

Resident G's record was reviewed on 3/18/25. The record documentation indicated the following:

- The Administration note, dated 1/10/25 at 5:03 p.m., indicated the Wellness Assessment for Medicaid was completed on every day shift. The resident passed away.

- The Administration note, dated 1/13/25 at 2:27 p.m., indicated the Wellness Assessment for Medicaid was completed on every day shift. The resident passed away.

- The Administration note, dated 1/15/25 at 3:00 p.m., indicated Wellness Assessment for Medicaid was completed on every day shift. The resident passed away.

- The Administration note, dated 1/17/25 at 4:53 p.m., indicated the resident was hospitalized.

- The Administration note, dated 1/18/25 at 12:15 p.m., indicated Wellness Assessment for Medicaid was completed on every day shift. The resident passed away.

- The Administration note, dated 1/23/25 at 10:44 a.m., indicated Wellness Assessment for

admission/lease for completion.

Resident C moved out December 20th 2024 after giving a 30 day notice to vacate his apartment. Resident alleges that his rent for December 2024 was paid; and that he was owed a refund. Resident did not pay December rent, and was not owed a refund.

Balance owed at time final statement for month of December 2024 was provided to Resident C.

exhibit wheelchair non refundable deposit signature page & exhibit balance owed at move out

0030- addendum

Residents will receive a written itemized notice upon discharge or death of charges. This will be a final statement of billing.

All residents have the potential to be affected. If a resident discharges, an itemized billing statement of charges will be provided to the resident/POA within 30 days.

A tracking tool of residents that discharge will be kept ensuring all discharged residents are

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

Medicaid was completed on every day shift. The resident passed away. - The Administration note, dated 1/24/25 at 1:46 p.m., indicated Wellness Assessment for Medicaid was completed on every day shift. The resident passed away. - The Administration note, dated 1/25/25 at 3:32 p.m., indicated Wellness Assessment for Medicaid was completed on every day shift. The resident was deceased. - The Administration note, dated 1/26/25 at 1:41 p.m., indicated Wellness Assessment for Medicaid was completed on every day shift. The resident was deceased. - The Administration note, dated 1/27/25 at 10:46 a.m., indicated Wellness Assessment for Medicaid was completed on every day shift. The resident had passed. - The Administration note, dated 1/28/25 at 1:43 p.m., indicated Wellness Assessment for Medicaid was completed on every day shift. The resident was expired. The Facility Census Form indicated, on 1/10/25, Resident G had expired. The Facility Census Form	provided with a copy itemized statement of charges. During daily stand up/morning meeting, the Business Office manager, Executive Director or designee will review the tracking form of discharged residents. The written itemized notice for each discharged resident will be uploaded to the residents EMR. How will the corrective actions be monitored to ensure the deficient practice does not reoccur? The BOM/ED will review discharges in daily stand up; the tracking form will be completed to ensure a copy of the itemized statement of charges are provided to resident/POA & uploaded into the residents EMR. The deficient practice will be added to the community monthly QA to ensure the final itemized statements are provided to the resident/POA & uploaded to the residents EMR. During monthly QA, the tracking tool will be reviewed to ensure all discharged residents received a copy of the itemized list of charges. This will occur monthly	
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DEPARTMENT OF HEALTH AND HUMAN SERVICES
CENTERS FOR MEDICARE & MEDICAID SERVICES

indicated, on 1/24/25, the facility was to stop billing. The record lacked documentation indicating the resident representative received a written notice including a list of itemized charges be deducted upon death. 3. The nurse's note, dated 2/5/25 at 12:35 p.m., indicated the nurse was alerted by a Qualified Medication Aide (QMA) that Resident J had no pulse or breathing. The nurse went to the resident's room with a second nurse, and two nurses verified that the resident had no heartbeat or respirations. The time of death was 2/5/25 at 8:25 a.m. The resident's family was at the resident's bedside. A call was placed to hospice, the Nurse Practitioner (NP), Director of Nursing (DON), Assistant Director of Nursing (ADON). The resident's remains were picked up by the funeral home at 10:55 a.m. The Facility Census Form indicated, on 2/5/25, Resident J had expired. The Facility Census Form indicated, on 3/1/25, the facility was to stop billing. The record lacked documentation indicating the resident representative received a written notice including a list of itemized charges be deducted		for 6 months, then every 60 days thereafter. Any identified concerns will be addressed at the monthly QA meeting. This systemic change will be completed by April 30th 2025. Insert discharged residents tracking tool	
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DEPARTMENT OF HEALTH AND HUMAN SERVICES
CENTERS FOR MEDICARE & MEDICAID SERVICES

upon death.

During an interview, on 3/18/25 at 12:26 p.m., the Marketing Director indicated family could request for the last remaining belongings to be stored out of the resident's room. They would have to request that, and they would be charged for the room if the belongings were left in the room. She did not know of any family leaving the resident's belongings in the room for a month after discharge or death.

An e-mail was sent, on 3/18/25 at 1:43 p.m., to the Regional Compliance Officer related to documentation and billing. Regional Compliance Officer 51 failed to respond to the enquirer.

During an interview, on 3/18/25 at 2:20 p.m., the Business Office Manager, indicated the facility went by the move-out date. The 5th and the 20th would be billed until the room was emptied. If there was time in the month, a prorated amount would be charged. If there was still furniture and the family hadn't returned the pendant and keys, they would be charged for the room. They would hold off until after the funeral to be respectful. They would not be told that this could be stored to prevent charges. The security refund was not available. The prorated amount took 30 days

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

to refund. The Integrated Health Care Coordination (IHCC) documentation would have to be completed. This would not be for financial reasons.

During an interview, on 3/18/25 at 2:27 p.m., the DON indicated the IHCC documentation could not be taken out of the system for Medicaid. The corporate office would not let them remove the documentation from the notes.

During an interview, on 3/18/25 at 2:46 p.m., the Maintenance Director and Housekeeping Director, indicated they both took care of the rooms once a resident was discharged or died. The family picked up the belongings. The Business Office Manager or someone in the office would notify the family to pick up the resident's belongings. The families would come within a week to get the resident's belongings. There was no place to store the furniture in the facility. The room would have to be charged if the belongings were not removed. The Executive Director would notify the family also. Some family or residents had donated their belongings before. No residents' belongings had ever been placed into the parking lot. When covid was in the building, resident belongings were placed at the curb for disposal. A family of a recently deceased resident

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

had not taken the resident's belongings for 1 to 2 weeks, but it had never taken a month or more. Some families had placed a mattress by the facility dumpster without permission. The city would have to be notified to pick it up if they had done that.

The Priority Life Care Community policy, dated 6/5/24, included, but was not limited to, " ...Security deposit must be treated in accordance with Indiana Code 32-31-3. Landlords cannot ask tenants to waive the security deposit regulation/rights under the Indiana Code. Upon termination of a rental agreement, the full amount of security deposit must be returned to the tenant, minus any amount applied for (1) the payment of accrued unpaid rent, (2) the amount of damages (not including normal wear and tear) caused by the tenant, and (3) unpaid utility charges that the tenant is obligated to pay. Per Indiana Code, within 45 days of the termination of the rental agreement, the landlord must send to the tenant (1) a written notice including an itemized list of all charges to be deducted from the security deposit including the estimated cost of repair for each damaged item and (2) payment for the difference between the security deposit held and the amount of damages claimed. Within thirty

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

(30) business days after you vacate and remove all of your property from your Apartment, we shall refund you or your estate any unused portion of your final Monthly Fee, minus (i) any Monthly Fees, fees for additional services, or other charges you owe to us; and (ii) any expense incurred by us to discard personal property that was not removed when you vacate your Apartment. If the sum you owe to us exceeds the unused portion of your final Monthly Fee, we will bill you or your estate for the difference."

This Citation relates to Complaint IN00454400.

Based on record review and interview, the facility failed to ensure that a resident received the full amount of security deposit, a written notice including an itemized list of charges, and prorated rent upon discharge or death for 3 of 9 residents reviewed for billing. (Residents C, G and J)"

Findings include:

1. During an interview, on 3/18/25 at 11:19 a.m., Resident C indicated the Executive Director (ED) had not returned his prorated rent. He indicated he moved out of the facility on 12/20/24.

The resident's record lacked documentation of the resident

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

receiving a written notice including a list of itemized charges to be deducted.

During an interview, on 3/18/25 at 11:45 a.m., the Marketing Director indicated when a resident was discharged or death, the billing would stop billing when the resident's belongings were removed, and the key was turned back into the facility.

During an interview, on 3/18/25 at 1:30 p.m., a phone call was made to the Administrative Billing in the corporate office to inquire about their policy regarding documentation and billing after a death or discharge. The facility office manager indicated the number and name of who to contact for the administrative billing corporate office. During the multiple attempts to contact the corporate office, Corporate Staff Member 50, indicated she was unwilling to talk.

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

2. The Communication note with Resident G's family, dated 1/10/25 at 12:15 p.m., indicated staff notified the family member of Resident G's death. The family member wished to contact the rest of the family. The funeral home was contacted per the resident's wishes. The funeral home arrived to transport the resident's body.

Resident G's record was reviewed on 3/18/25. The record documentation indicated the following:

- The Administration note, dated 1/10/25 at 5:03 p.m., indicated the Wellness Assessment for Medicaid was completed on every day shift. The resident passed away.

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- The Administration note, dated 1/17/25 at 4:53 p.m., indicated the resident was hospitalized.

- The Administration note, dated

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

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- The Administration note, dated 1/25/25 at 3:32 p.m., indicated Wellness Assessment for Medicaid was completed on every day shift. The resident was deceased.

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

Medicaid was completed on every day shift. The resident was expired.

The Facility Census Form indicated, on 1/10/25, Resident G had expired.

The Facility Census Form indicated, on 1/24/25, the facility was to stop billing.

The record lacked documentation indicating the resident representative received a written notice including a list of itemized charges be deducted upon death.

3. The nurse's note, dated 2/5/25 at 12:35 p.m., indicated the nurse was alerted by a Qualified Medication Aide (QMA) that Resident J had no pulse or breathing. The nurse went to the resident's room with a second nurse, and two nurses verified that the resident had no heartbeat or respirations. The time of death was 2/5/25 at 8:25 a.m. The resident's family was at the resident's bedside. A call was placed to hospice, the Nurse Practitioner (NP), Director of Nursing (DON), Assistant Director of Nursing (ADON). The resident's remains were picked up by the funeral home at 10:55 a.m.

The Facility Census Form indicated, on 2/5/25, Resident J had expired.

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

The Facility Census Form indicated, on 3/1/25, the facility was to stop billing.

The record lacked documentation indicating the resident representative received a written notice including a list of itemized charges be deducted upon death.

During an interview, on 3/18/25 at 12:26 p.m., the Marketing Director indicated family could request for the last remaining belongings to be stored out of the resident's room. They would have to request that, and they would be charged for the room if the belongings were left in the room. She did not know of any family leaving the resident's belongings in the room for a month after discharge or death.

An e-mail was sent, on 3/18/25 at 1:43 p.m., to the Regional Compliance Officer related to documentation and billing. Regional Compliance Officer 51 failed to respond to the enquirer.

During an interview, on 3/18/25 at 2:20 p.m., the Business Office Manager, indicated the facility went by the move-out date. The 5th and the 20th would be billed until the room was emptied. If there was time in the month, a prorated amount would be charged. If there was still furniture and the family

hadn't returned the pendant and keys, they would be charged for the room. They would hold off until after the funeral to be respectful. They would not be told that this could be stored to prevent charges. The security refund was not available. The prorated amount took 30 days to refund. The Integrated Health Care Coordination (IHCC) documentation would have to be completed. This would not be for financial reasons.

During an interview, on 3/18/25 at 2:27 p.m., the DON indicated the IHCC documentation could not be taken out of the system for Medicaid. The corporate office would not let them remove the documentation from the notes.

During an interview, on 3/18/25 at 2:46 p.m., the Maintenance Director and Housekeeping Director, indicated they both took care of the rooms once a resident was discharged or died. The family picked up the belongings. The Business Office Manager or someone in the office would notify the family to pick up the resident's belongings. The families would come within a week to get the resident's belongings. There was no place to store the furniture in the facility. The room would have to be charged if the belongings were not removed. The Executive Director would

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

notify the family also. Some family or residents had donated their belongings before. No residents' belongings had ever been placed into the parking lot. When covid was in the building, resident belongings were placed at the curb for disposal. A family of a recently deceased resident had not taken the resident's belongings for 1 to 2 weeks, but it had never taken a month or more. Some families had placed a mattress by the facility dumpster without permission. The city would have to be notified to pick it up if they had done that.

The Priority Life Care Community policy, dated 6/5/24, included, but was not limited to, " ...Security deposit must be treated in accordance with Indiana Code 32-31-3. Landlords cannot ask tenants to waive the security deposit regulation/rights under the Indiana Code. Upon termination of a rental agreement, the full amount of security deposit must be returned to the tenant, minus any amount applied for (1) the payment of accrued unpaid rent, (2) the amount of damages (not including normal wear and tear) caused by the tenant, and (3) unpaid utility charges that the tenant is obligated to pay. Per Indiana Code, within 45 days of the termination of the rental agreement, the landlord must send to the tenant (1) a written

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

notice including an itemized list of all charges to be deducted from the security deposit including the estimated cost of repair for each damaged item and (2) payment for the difference between the security deposit held and the amount of damages claimed. Within thirty (30) business days after you vacate and remove all of your property from your Apartment, we shall refund you or your estate any unused portion of your final Monthly Fee, minus (i) any Monthly Fees, fees for additional services, or other charges you owe to us; and (ii) any expense incurred by us to discard personal property that was not removed when you vacate your Apartment. If the sum you owe to us exceeds the unused portion of your final Monthly Fee, we will bill you or your estate for the difference."

This Citation relates to Complaint IN00454400.

Based on record review and interview, the facility failed to ensure that a resident received the full amount of security deposit, a written notice including an itemized list of charges, and prorated rent upon discharge or death for 3 of 9 residents reviewed for billing. (Residents C, G and J)"

Findings include:

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

1. During an interview, on 3/18/25 at 11:19 a.m., Resident C indicated the Executive Director (ED) had not returned his prorated rent. He indicated he moved out of the facility on 12/20/24.

The resident's record lacked documentation of the resident receiving a written notice including a list of itemized charges to be deducted.

During an interview, on 3/18/25 at 11:45 a.m., the Marketing Director indicated when a resident was discharged or death, the billing would stop billing when the resident's belongings were removed, and the key was turned back into the facility.

During an interview, on 3/18/25 at 1:30 p.m., a phone call was made to the Administrative Billing in the corporate office to inquire about their policy regarding documentation and billing after a death or discharge. The facility office manager indicated the number and name of who to contact for the administrative billing corporate office. During the multiple attempts to contact the corporate office, Corporate Staff Member 50, indicated she was unwilling to talk.

2. The Communication note with Resident G's family, dated

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

1/10/25 at 12:15 p.m., indicated staff notified the family member of Resident G's death. The family member wished to contact the rest of the family. The funeral home was contacted per the resident's wishes. The funeral home arrived to transport the resident's body.

Resident G's record was reviewed on 3/18/25. The record documentation indicated the following:

- The Administration note, dated 1/10/25 at 5:03 p.m., indicated the Wellness Assessment for Medicaid was completed on every day shift. The resident passed away.

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

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

was expired.

The Facility Census Form indicated, on 1/10/25, Resident G had expired.

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The record lacked documentation indicating the resident representative received a written notice including a list of itemized charges be deducted upon death.

3. The nurse's note, dated 2/5/25 at 12:35 p.m., indicated the nurse was alerted by a Qualified Medication Aide (QMA) that Resident J had no pulse or breathing. The nurse went to the resident's room with a second nurse, and two nurses verified that the resident had no heartbeat or respirations. The time of death was 2/5/25 at 8:25 a.m. The resident's family was at the resident's bedside. A call was placed to hospice, the Nurse Practitioner (NP), Director of Nursing (DON), Assistant Director of Nursing (ADON). The resident's remains were picked up by the funeral home at 10:55 a.m.

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

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During an interview, on 3/18/25 at 12:26 p.m., the Marketing Director indicated family could request for the last remaining belongings to be stored out of the resident's room. They would have to request that, and they would be charged for the room if the belongings were left in the room. She did not know of any family leaving the resident's belongings in the room for a month after discharge or death.

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

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

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The Priority Life Care Community policy, dated 6/5/24, included, but was not limited to, " ...Security deposit must be treated in accordance with Indiana Code 32-31-3. Landlords cannot ask tenants to waive the security deposit regulation/rights under the Indiana Code. Upon termination of a rental agreement, the full amount of security deposit must be returned to the tenant, minus any amount applied for (1) the payment of accrued unpaid rent, (2) the amount of damages (not including normal wear and tear) caused by the tenant, and (3) unpaid utility charges that the tenant is obligated to pay. Per Indiana Code, within 45 days of the termination of the rental agreement, the landlord must send to the tenant (1) a written notice including an itemized list of all charges to be deducted

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

from the security deposit including the estimated cost of repair for each damaged item and (2) payment for the difference between the security deposit held and the amount of damages claimed. Within thirty (30) business days after you vacate and remove all of your property from your Apartment, we shall refund you or your estate any unused portion of your final Monthly Fee, minus (i) any Monthly Fees, fees for additional services, or other charges you owe to us; and (ii) any expense incurred by us to discard personal property that was not removed when you vacate your Apartment. If the sum you owe to us exceeds the unused portion of your final Monthly Fee, we will bill you or your estate for the difference."

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Based on record review and interview, the facility failed to ensure that a resident received the full amount of security deposit, a written notice including an itemized list of charges, and prorated rent upon discharge or death for 3 of 9 residents reviewed for billing. (Residents C, G and J)"

Findings include:

1. During an interview, on 3/18/25 at 11:19 a.m., Resident

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

C indicated the Executive Director (ED) had not returned his prorated rent. He indicated he moved out of the facility on 12/20/24.

The resident's record lacked documentation of the resident receiving a written notice including a list of itemized charges to be deducted.

During an interview, on 3/18/25 at 11:45 a.m., the Marketing Director indicated when a resident was discharged or death, the billing would stop billing when the resident's belongings were removed, and the key was turned back into the facility.

During an interview, on 3/18/25 at 1:30 p.m., a phone call was made to the Administrative Billing in the corporate office to inquire about their policy regarding documentation and billing after a death or discharge. The facility office manager indicated the number and name of who to contact for the administrative billing corporate office. During the multiple attempts to contact the corporate office, Corporate Staff Member 50, indicated she was unwilling to talk.

2. The Communication note with Resident G's family, dated 1/10/25 at 12:15 p.m., indicated staff notified the family member

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

of Resident G's death. The family member wished to contact the rest of the family. The funeral home was contacted per the resident's wishes. The funeral home arrived to transport the resident's body.

Resident G's record was reviewed on 3/18/25. The record documentation indicated the following:

- The Administration note, dated 1/10/25 at 5:03 p.m., indicated the Wellness Assessment for Medicaid was completed on every day shift. The resident passed away.

- The Administration note, dated 1/13/25 at 2:27 p.m., indicated the Wellness Assessment for Medicaid was completed on every day shift. The resident passed away.

- The Administration note, dated 1/15/25 at 3:00 p.m., indicated Wellness Assessment for Medicaid was completed on every day shift. The resident passed away.

- The Administration note, dated 1/17/25 at 4:53 p.m., indicated the resident was hospitalized.

- The Administration note, dated 1/18/25 at 12:15 p.m., indicated Wellness Assessment for Medicaid was completed on every day shift. The resident

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

passed away.

- The Administration note, dated 1/23/25 at 10:44 a.m., indicated Wellness Assessment for Medicaid was completed on every day shift. The resident passed away.

- The Administration note, dated 1/24/25 at 1:46 p.m., indicated Wellness Assessment for Medicaid was completed on every day shift. The resident passed away.

- The Administration note, dated 1/25/25 at 3:32 p.m., indicated Wellness Assessment for Medicaid was completed on every day shift. The resident was deceased.

- The Administration note, dated 1/26/25 at 1:41 p.m., indicated Wellness Assessment for Medicaid was completed on every day shift. The resident was deceased.

- The Administration note, dated 1/27/25 at 10:46 a.m., indicated Wellness Assessment for Medicaid was completed on every day shift. The resident had passed.

- The Administration note, dated 1/28/25 at 1:43 p.m., indicated Wellness Assessment for Medicaid was completed on every day shift. The resident was expired.

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

The Facility Census Form indicated, on 1/10/25, Resident G had expired.

The Facility Census Form indicated, on 1/24/25, the facility was to stop billing.

The record lacked documentation indicating the resident representative received a written notice including a list of itemized charges be deducted upon death.

3. The nurse's note, dated 2/5/25 at 12:35 p.m., indicated the nurse was alerted by a Qualified Medication Aide (QMA) that Resident J had no pulse or breathing. The nurse went to the resident's room with a second nurse, and two nurses verified that the resident had no heartbeat or respirations. The time of death was 2/5/25 at 8:25 a.m. The resident's family was at the resident's bedside. A call was placed to hospice, the Nurse Practitioner (NP), Director of Nursing (DON), Assistant Director of Nursing (ADON). The resident's remains were picked up by the funeral home at 10:55 a.m.

The Facility Census Form indicated, on 2/5/25, Resident J had expired.

The Facility Census Form indicated, on 3/1/25, the facility was to stop billing.

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

The record lacked documentation indicating the resident representative received a written notice including a list of itemized charges be deducted upon death.

During an interview, on 3/18/25 at 12:26 p.m., the Marketing Director indicated family could request for the last remaining belongings to be stored out of the resident's room. They would have to request that, and they would be charged for the room if the belongings were left in the room. She did not know of any family leaving the resident's belongings in the room for a month after discharge or death.

An e-mail was sent, on 3/18/25 at 1:43 p.m., to the Regional Compliance Officer related to documentation and billing. Regional Compliance Officer 51 failed to respond to the enquirer.

During an interview, on 3/18/25 at 2:20 p.m., the Business Office Manager, indicated the facility went by the move-out date. The 5th and the 20th would be billed until the room was emptied. If there was time in the month, a prorated amount would be charged. If there was still furniture and the family hadn't returned the pendant and keys, they would be charged for the room. They would hold off until after the funeral to be

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

respectful. They would not be told that this could be stored to prevent charges. The security refund was not available. The prorated amount took 30 days to refund. The Integrated Health Care Coordination (IHCC) documentation would have to be completed. This would not be for financial reasons.

During an interview, on 3/18/25 at 2:27 p.m., the DON indicated the IHCC documentation could not be taken out of the system for Medicaid. The corporate office would not let them remove the documentation from the notes.

During an interview, on 3/18/25 at 2:46 p.m., the Maintenance Director and Housekeeping Director, indicated they both took care of the rooms once a resident was discharged or died. The family picked up the belongings. The Business Office Manager or someone in the office would notify the family to pick up the resident's belongings. The families would come within a week to get the resident's belongings. There was no place to store the furniture in the facility. The room would have to be charged if the belongings were not removed. The Executive Director would notify the family also. Some family or residents had donated their belongings before. No residents' belongings had ever

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

been placed into the parking lot. When covid was in the building, resident belongings were placed at the curb for disposal. A family of a recently deceased resident had not taken the resident's belongings for 1 to 2 weeks, but it had never taken a month or more. Some families had placed a mattress by the facility dumpster without permission. The city would have to be notified to pick it up if they had done that.

The Priority Life Care Community policy, dated 6/5/24, included, but was not limited to, " ...Security deposit must be treated in accordance with Indiana Code 32-31-3. Landlords cannot ask tenants to waive the security deposit regulation/rights under the Indiana Code. Upon termination of a rental agreement, the full amount of security deposit must be returned to the tenant, minus any amount applied for (1) the payment of accrued unpaid rent, (2) the amount of damages (not including normal wear and tear) caused by the tenant, and (3) unpaid utility charges that the tenant is obligated to pay. Per Indiana Code, within 45 days of the termination of the rental agreement, the landlord must send to the tenant (1) a written notice including an itemized list of all charges to be deducted from the security deposit including the estimated cost of

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

repair for each damaged item and (2) payment for the difference between the security deposit held and the amount of damages claimed. Within thirty (30) business days after you vacate and remove all of your property from your Apartment, we shall refund you or your estate any unused portion of your final Monthly Fee, minus (i) any Monthly Fees, fees for additional services, or other charges you owe to us; and (ii) any expense incurred by us to discard personal property that was not removed when you vacate your Apartment. If the sum you owe to us exceeds the unused portion of your final Monthly Fee, we will bill you or your estate for the difference."

This Citation relates to Complaint IN00454400.

Based on record review and interview, the facility failed to ensure that a resident received the full amount of security deposit, a written notice including an itemized list of charges, and prorated rent upon discharge or death for 3 of 9 residents reviewed for billing. (Residents C, G and J)"

Findings include:

1. During an interview, on 3/18/25 at 11:19 a.m., Resident C indicated the Executive Director (ED) had not returned

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

	his prorated rent. He indicated he moved out of the facility on 12/20/24. The resident's record lacked documentation of the resident receiving a written notice including a list of itemized charges to be deducted. During an interview, on 3/18/25 at 11:45 a.m., the Marketing Director indicated when a resident was discharged or death, the billing would stop billing when the resident's belongings were removed, and the key was turned back into the facility. During an interview, on 3/18/25 at 1:30 p.m., a phone call was made to the Administrative Billing in the corporate office to inquire about their policy regarding documentation and billing after a death or discharge. The facility office manager indicated the number and name of who to contact for the administrative billing corporate office. During the multiple attempts to contact the corporate office, Corporate Staff Member 50, indicated she was unwilling to talk.			
R 0039	Residents' Rights- Deficiency 410 IAC 16.2-5-1.2(n) (n) Residents may, throughout the period of their stay, voice	R 0039	R 039 Grievances- It is the policy of Vivera Senior Living of Jeffersonville to ensure family and residents are able to voice grievances to	04/30/2025

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

grievances to the facility staff or to an outside representative of their choice, recommend changes in policy and procedure, and receive reasonable responses to their requests without fear of reprisal or interference.

2. The nurse's note, dated 11/27/24 at 4:33 p.m., indicated Resident C approached the front desk and asked to meet with Executive Director (ED). The ED asked the Maintenance supervisor to witness the conversation as the resident had been cursing and threatened the ED previously. The ED advised the resident that they would not be meeting due to his behavior and cussing. The Maintenance Supervisor attempted to redirect the resident due to his language. Resident C returned to his room threatening to sue the facility, which was his usual behavior.

During an interview, on 3/18/25 at 11:19 a.m., Resident C indicated the ED did not know how to talk to the residents. He had requested to speak to the ED in private four times in one month. She finally told him she did not talk to anyone in private. She would stand out by the desk and talk to the residents. The ED would not sit down with any of the residents in private. The resident didn't want to talk in front of the other residents because he wanted privacy.

the facility staff.

What Corrective actions will be accomplished for those residents found to be have been affected by the deficient practices: Residents were educated at Resident Council Meeting on April 8th of the grievance policy. All current residents were given a written policy of grievance reporting policy on April 8th, 2025. exhibit grievance

How the facility will identify other residents having the potential to be affected by the same deficient practice: All current residents were given grievance reporting policy. All new admissions are given a copy of the grievance policy.

What measures will be put into place or what systemic changes will the facility make to ensure that the deficient practice does not recur. Grievance reporting policy will be given to

Anytime a resident complained about anything, the ED was quick to say, "If you don't like it here you can leave." The resident indicated he moved out of the facility on 12/20/24. He had become upset because he had tried several times to meet with the ED.

3. During a confidential interview, on 3/18/25 between 8:45 a.m. and 3:00 p.m., Resident K indicated they had requested several times to talk to the ED in private and she would not talk to them. The resident really hadn't seen the ED but a couple of times, because she did not talk to the residents. Nothing was being done about the residents' concerns.

4. During a confidential interview, on 3/18/25 between 8:45 a.m. and 3:00 p.m., Resident L indicated the ED was not available to talk to privately. The resident had requested to talk to the ED, and the ED refused. The ED was not a compassionate person and never talked to the residents.

The Resident Rights policy, dated 2/8/23, included, but was not limited to, " ...Every resident, resident's representative and resident's legal representative, if any shall have the right to present grievances on behalf of himself or herself or others, to

each new move in/resident and given to each current resident.

How the corrective actions will be monitored to ensure the deficient practice will not recur.

Residents will be educated monthly at the resident council meetings starting April 2025 on the grievance policy and continue through the end of the year.

0039 addendum

Grievances from residents/responsible party will be addressed and escalated to corporate if not resolved at the community level.

Grievances will be reported to the Executive Director. Grievances will be addressed by the appropriate Department Supervisor/Executive Director. If grievances are not resolved; a Regional Director will hold a meeting with the resident/responsible party to resolve concern.

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

the resident's staff, Executive Director or assisted living operator, to governmental officials to long term care ombudsmen or to any other person without fear of reprisal, and to join with other residents or individuals within or outside of the residence to work for improvements in resident care; ..."

The Priority Life Care Community policy, dated 6/5/24, included, but was not limited to, " ...If you have a grievance or complaint regarding the Community you may contact the Executive Director or the Community's corporate headquarters..."

On 1/24/25, the Wellness Director gave an in-service on Resident Rights and Abuse to the staff. Review of the information given to the staff included, but was not limited to, "Responsive Service: Policy: Residents should have the right to a prompt and reasonable response to their requests and questions. Grievances: Policy: Residents should be encouraged and assisted, throughout their stay at the community or their course of treatment, in order to understand and exercise their rights as residents, patients, and citizens. Residents may voice grievances and recommend change in policies and

All residents have the potential to be affected. Residents may report concerns to Executive Director/designee or fill out a concern form. These forms can be filled out by the resident/responsible party with help from staff member if necessary. The Executive Director and appropriate Department manager will meet with resident to resolve grievance. If a resident/responsible party relays that a concern is not resolved, a Regional Director will reach out to the resident/responsible party to meet. Additional options to report concerns are: corporate email, corporate hotline phone number, monthly Resident Council and an anonymous grievance box located in the lobby.

All concerns will be addressed and resolved within 5 business days. Concern forms will be used to track concerns to ensure resolution. Executive Director or designee will review concern forms weekly to ensure resolution or escalate to Regional Director.

The deficient practice will be added to the community monthly QA to ensure that grievances are addressed.

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

procedures and services to community staff and others of their choice, free from fear of restraint, interference, coercion, discrimination, or reprisal, including threat of discharge...Procedure: 1. Every effort should be made by the senior living community to address a grievance or concern of a resident..."

This Citation relates to Complaint IN00454400.

Based on record review and interview, the facility failed to ensure the residents and/or family were able to voice grievances to the facility staff and received reasonable responses to their requests for 4 of 9 residents reviewed for Resident Rights. (Residents F, C, L, and K)

Findings include:

1. An email from Resident F's family member to the Executive Director (ED), dated 2/9/25 at 3:07 p.m., indicated he was very frustrated with the way the resident's assessments had been handled as it seemed as though the resident was set up to fail. He indicated that every time he asked about her assessments, he was given a different answer. He had been told an assessment was going to be held during a specific timeframe, and that schedule

Concern forms will be reviewed in monthly QA meetings to ensure grievances are resolved. This review of concern forms will happen monthly in QA for 6 months; then every 60 days thereafter. Any identified concerns will be identified in monthly QA meeting, and escalated to Regional Director as needed.

The systemic changes will be completed by April 30th 2025.

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

was not kept.

A return email from the ED, dated 2/10/25 at 10:39 a.m., indicated the family member was informed she was not being deceitful, the DON only stopped in to check on the resident on the day when she was there to see another resident.

2. The nurse's note, dated 11/27/24 at 4:33 p.m., indicated Resident C approached the front desk and asked to meet with Executive Director (ED). The ED asked the Maintenance supervisor to witness the conversation as the resident had been cursing and threatened the ED previously. The ED advised the resident that they would not be meeting due to his behavior and cussing. The Maintenance Supervisor attempted to redirect the resident due to his language. Resident C returned to his room threatening to sue the facility, which was his usual behavior.

During an interview, on 3/18/25 at 11:19 a.m., Resident C indicated the ED did not know how to talk to the residents. He had requested to speak to the ED in private four times in one month. She finally told him she did not talk to anyone in private. She would stand out by the desk and talk to the residents. The ED would not sit down with any of the residents in private.

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

The resident didn't want to talk in front of the other residents because he wanted privacy. Anytime a resident complained about anything, the ED was quick to say, "If you don't like it here you can leave." The resident indicated he moved out of the facility on 12/20/24. He had become upset because he had tried several times to meet with the ED.

3. During a confidential interview, on 3/18/25 between 8:45 a.m. and 3:00 p.m., Resident K indicated they had requested several times to talk to the ED in private and she would not talk to them. The resident really hadn't seen the ED but a couple of times, because she did not talk to the residents. Nothing was being done about the residents' concerns.

4. During a confidential interview, on 3/18/25 between 8:45 a.m. and 3:00 p.m., Resident L indicated the ED was not available to talk to privately. The resident had requested to talk to the ED, and the ED refused. The ED was not a compassionate person and never talked to the residents.

The Resident Rights policy, dated 2/8/23, included, but was not limited to, " ...Every resident, resident's representative and resident's legal representative, if

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

any shall have the right to present grievances on behalf of himself or herself or others, to the resident's staff, Executive Director or assisted living operator, to governmental officials to long term care ombudsmen or to any other person without fear of reprisal, and to join with other residents or individuals within or outside of the residence to work for improvements in resident care; ..."

The Priority Life Care Community policy, dated 6/5/24, included, but was not limited to, " ...If you have a grievance or complaint regarding the Community you may contact the Executive Director or the Community's corporate headquarters..."

On 1/24/25, the Wellness Director gave an in-service on Resident Rights and Abuse to the staff. Review of the information given to the staff included, but was not limited to, "Responsive Service: Policy: Residents should have the right to a prompt and reasonable response to their requests and questions. Grievances: Policy: Residents should be encouraged and assisted, throughout their stay at the community or their course of treatment, in order to understand and exercise their rights as residents, patients, and

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

citizens. Residents may voice grievances and recommend change in policies and procedures and services to community staff and others of their choice, free from fear of restraint, interference, coercion, discrimination, or reprisal, including threat of discharge...Procedure: 1. Every effort should be made by the senior living community to address a grievance or concern of a resident..."

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Based on record review and interview, the facility failed to ensure the residents and/or family were able to voice grievances to the facility staff and received reasonable responses to their requests for 4 of 9 residents reviewed for Resident Rights. (Residents F, C, L, and K)

Findings include:

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

told an assessment was going to be held during a specific timeframe, and that schedule was not kept.

A return email from the ED, dated 2/10/25 at 10:39 a.m., indicated the family member was informed she was not being deceitful, the DON only stopped in to check on the resident on the day when she was there to see another resident.

2. The nurse's note, dated 11/27/24 at 4:33 p.m., indicated Resident C approached the front desk and asked to meet with Executive Director (ED). The ED asked the Maintenance supervisor to witness the conversation as the resident had been cursing and threatened the ED previously. The ED advised the resident that they would not be meeting due to his behavior and cussing. The Maintenance Supervisor attempted to redirect the resident due to his language. Resident C returned to his room threatening to sue the facility, which was his usual behavior.

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

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4. During a confidential interview, on 3/18/25 between 8:45 a.m. and 3:00 p.m., Resident L indicated the ED was not available to talk to privately. The resident had requested to talk to the ED, and the ED refused. The ED was not a compassionate person and never talked to the residents.

The Resident Rights policy, dated 2/8/23, included, but was

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

not limited to, " ...Every resident, resident's representative and resident's legal representative, if any shall have the right to present grievances on behalf of himself or herself or others, to the resident's staff, Executive Director or assisted living operator, to governmental officials to long term care ombudsmen or to any other person without fear of reprisal, and to join with other residents or individuals within or outside of the residence to work for improvements in resident care; ..."

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On 1/24/25, the Wellness Director gave an in-service on Resident Rights and Abuse to the staff. Review of the information given to the staff included, but was not limited to, "Responsive Service: Policy: Residents should have the right to a prompt and reasonable response to their requests and questions. Grievances: Policy: Residents should be encouraged and assisted, throughout their stay at the community or their course of

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

treatment, in order to understand and exercise their rights as residents, patients, and citizens. Residents may voice grievances and recommend change in policies and procedures and services to community staff and others of their choice, free from fear of restraint, interference, coercion, discrimination, or reprisal, including threat of discharge...Procedure: 1. Every effort should be made by the senior living community to address a grievance or concern of a resident..."

This Citation relates to Complaint IN00454400.

Based on record review and interview, the facility failed to ensure the residents and/or family were able to voice grievances to the facility staff and received reasonable responses to their requests for 4 of 9 residents reviewed for Resident Rights. (Residents F, C, L, and K)

Findings include:

1. An email from Resident F's family member to the Executive Director (ED), dated 2/9/25 at 3:07 p.m., indicated he was very frustrated with the way the resident's assessments had been handled as it seemed as though the resident was set up to fail. He indicated that every

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

time he asked about her assessments, he was given a different answer. He had been told an assessment was going to be held during a specific timeframe, and that schedule was not kept.

A return email from the ED, dated 2/10/25 at 10:39 a.m., indicated the family member was informed she was not being deceitful, the DON only stopped in to check on the resident on the day when she was there to see another resident.

2. The nurse's note, dated 11/27/24 at 4:33 p.m., indicated Resident C approached the front desk and asked to meet with Executive Director (ED). The ED asked the Maintenance supervisor to witness the conversation as the resident had been cursing and threatened the ED previously. The ED advised the resident that they would not be meeting due to his behavior and cussing. The Maintenance Supervisor attempted to redirect the resident due to his language. Resident C returned to his room threatening to sue the facility, which was his usual behavior.

During an interview, on 3/18/25 at 11:19 a.m., Resident C indicated the ED did not know how to talk to the residents. He had requested to speak to the ED in private four times in one

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

month. She finally told him she did not talk to anyone in private. She would stand out by the desk and talk to the residents. The ED would not sit down with any of the residents in private. The resident didn't want to talk in front of the other residents because he wanted privacy. Anytime a resident complained about anything, the ED was quick to say, "If you don't like it here you can leave." The resident indicated he moved out of the facility on 12/20/24. He had become upset because he had tried several times to meet with the ED.

3. During a confidential interview, on 3/18/25 between 8:45 a.m. and 3:00 p.m., Resident K indicated they had requested several times to talk to the ED in private and she would not talk to them. The resident really hadn't seen the ED but a couple of times, because she did not talk to the residents. Nothing was being done about the residents' concerns.

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

4. During a confidential interview, on 3/18/25 between 8:45 a.m. and 3:00 p.m., Resident L indicated the ED was not available to talk to privately. The resident had requested to talk to the ED, and the ED refused. The ED was not a compassionate person and never talked to the residents.

The Resident Rights policy, dated 2/8/23, included, but was not limited to, " ...Every resident, resident's representative and resident's legal representative, if any shall have the right to present grievances on behalf of himself or herself or others, to the resident's staff, Executive Director or assisted living operator, to governmental officials to long term care ombudsmen or to any other person without fear of reprisal, and to join with other residents or individuals within or outside of the residence to work for improvements in resident care; ..."

The Priority Life Care Community policy, dated 6/5/24, included, but was not limited to, " ...If you have a grievance or complaint regarding the Community you may contact the Executive Director or the Community's corporate headquarters..."

On 1/24/25, the Wellness Director gave an in-service on

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

Resident Rights and Abuse to the staff. Review of the information given to the staff included, but was not limited to, "Responsive Service: Policy: Residents should have the right to a prompt and reasonable response to their requests and questions. Grievances: Policy: Residents should be encouraged and assisted, throughout their stay at the community or their course of treatment, in order to understand and exercise their rights as residents, patients, and citizens. Residents may voice grievances and recommend change in policies and procedures and services to community staff and others of their choice, free from fear of restraint, interference, coercion, discrimination, or reprisal, including threat of discharge...Procedure: 1. Every effort should be made by the senior living community to address a grievance or concern of a resident..."

This Citation relates to Complaint IN00454400.

Based on record review and interview, the facility failed to ensure the residents and/or family were able to voice grievances to the facility staff and received reasonable responses to their requests for 4 of 9 residents reviewed for Resident Rights. (Residents F,

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

	C, L, and K) Findings include: 1. An email from Resident F's family member to the Executive Director (ED), dated 2/9/25 at 3:07 p.m., indicated he was very frustrated with the way the resident's assessments had been handled as it seemed as though the resident was set up to fail. He indicated that every time he asked about her assessments, he was given a different answer. He had been told an assessment was going to be held during a specific timeframe, and that schedule was not kept. A return email from the ED, dated 2/10/25 at 10:39 a.m., indicated the family member was informed she was not being deceitful, the DON only stopped in to check on the resident on the day when she was there to see another resident.			
R 0045	Residents' Rights - Deficiency 410 IAC 16.2-5-1.2(r)(6-9) (6) Before an interfacility transfer or discharge occurs, the facility must, on a form prescribed by the department, do the following: (A) Notify the resident of the transfer or discharge and the reasons for the move, in writing, and in a language and manner that	R 0045	R 045 - Resident Rights .It is the policy of Vivera Senior Living of Jeffersonville to notify the required state agencies when a resident is issued a 30 day notice of discharge for the appropriate reasons as described in 410 IAC 16.2-5-1.2(r) (1-5).	04/18/2025

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

the resident understands. The health facility must place a copy of the notice in the resident ' s clinical record and transmit a copy to the following:

- (i) The resident.
- (ii) A family member of the resident if known.
- (iii) The resident ' s legal representative if known.
- (iv) The local long term care ombudsman program (for involuntary relocations or discharges only).
- (v) The person or agency responsible for the resident ' s placement, maintenance, and care in the facility.
- (vi) In situations where the resident is developmentally disabled, the regional office of the division of disability, aging, and rehabilitative services, who may assist with placement decisions.
- (vii) The resident ' s physician when the transfer or discharge is necessary under subdivision (4)(C), (4)(D), (4)(E), or (4)(F).
- (B) Record the reasons in the resident ' s clinical record.
- (C) Include in the notice the items described in subdivision (9).
- (7) Except when specified in subdivision (8), the notice of transfer or discharge required under subdivision (6) must be made by the facility at least thirty (30) days before the resident is

What Corrective actions will be accomplished for those residents found to have been affected by the deficient practices: all required agencies will be notified via certified mail of 30 day discharge notices.

How the facility will identify other residents having the potential to be affected by the same deficient practice: all residents have the potential to be affected. The Executive Director or designee will complete audit tool for tracking certified mail of 30 day notice of discharges.

audit tool labeled 30 day notice tracking tool

What measures will be put into place or what systemic changes will the facility make to ensure that the deficient practice does not recur. Using the attached audit tool to track any 30 day notice discharges to ensure all agencies are notified with certified mail delivery. The audit tool will be completed weekly for four

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

transferred or discharged.

(8) Notice may be made as soon as practicable before transfer or discharge when:

(A) the safety of individuals in the facility would be endangered;

(B) the health of individuals in the facility would be endangered;

(C) the resident ' s health improves sufficiently to allow a more immediate transfer or discharge;

(D) an immediate transfer or discharge is required by the resident ' s urgent medical needs; or

(E) a resident has not resided in the facility for thirty (30) days.

(9) For health facilities, the written notice specified in subdivision (7) must include the following:

(A) The reason for transfer or discharge.

(B) The effective date of transfer or discharge.

(C) The location to which the resident is transferred or discharged.

(D) A statement in not smaller than 12-point bold type that reads, " You have the right to appeal the health facility ' s decision to transfer you. If you think you should not have to leave this facility, you may file a written request for a hearing with the Indiana state department of health postmarked within ten (10) days after you receive this notice. If

weeks then twice a month for three months then monthly thereafter.

How the corrective actions will be monitored to ensure the deficient practice will not recur. The audit tool will be used to track any 30 day discharges to track notifications of required of all state agencies when a 30 day discharge notice is issued.

By what date the systematic changes will be completed.
April 18th 2025.

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

you request a hearing, it will be held within twenty-three (23) days after you receive this notice, and you will not be transferred from the facility earlier than thirty-four (34) days after you receive this notice of transfer or discharge unless the facility is authorized to transfer you under subdivision (8). If you wish to appeal this transfer or discharge, a form to appeal the health facility's decision and to request a hearing is attached. If you have any questions, call the Indiana state department of health at the number listed below. " .

(E) The name of the director and the address, telephone number, and hours of operation of the division.

(F) A hearing request form prescribed by the department.

(G) The name, address, and telephone number of the state and local long term care ombudsman.

(H) For health facility residents with developmental disabilities or who are mentally ill, the mailing address and telephone number of the protection and advocacy services commission.

Based on record review and interview, the facility failed to notify the State Agencies (Ombudsman, Adult Protective Services, Area Agency on Aging and State Department of Health) when one resident was issued a 30-day Notice of Transfer/Discharge (Resident D), and one resident was

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

transferred to another facility without a 30-day Notice (Resident F). This deficient practice affected 2 of 4 residents reviewed for discharge. (Resident D and F)

Findings include:

1. The record for Resident D was reviewed on 3/18/25 at 11:00 a.m. The resident's diagnoses included, but were not limited to, asthma, atrial fibrillation and flutter, chronic lymphocytic leukemia of B-Cell type, chronic obstructive pulmonary disease, mild cognitive impairment of uncertain or unknown etiology and

bipolar disorder.

On 1/10/25, Resident D was issued a 30-day Transfer/Discharge Notice from the facility due to failure to make rent payments each month after a reasonable amount of time and appropriate notice to pay.

The review of the letter that accompanied the notice indicated the Long Term Care Ombudsman, the State Department of Health, Adult Protective Services, and Agency on Aging were notified of the Transfer/Discharge Notice.

During an interview with the local Ombudsman on 3/18/25 at 9:56 a.m., she indicated she

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

had not received a copy of the 30-Day Notice of Transfer/Discharge for this resident. Her supervisor had not received the notice either when she checked with her.

During an interview with the Director of Nursing (DON), on 3/18/25 at 12:20 p.m., she indicated she was unable to provide any documentation to show the State agencies had been notified of the plan to discharge Resident D.

2. The record for Resident F was reviewed on 3/18/25 at 1:30 p.m. The resident's diagnoses included, but were not limited to, unspecified dementia without behavioral disturbance, psychotic disturbance, mood disturbance, anxiety, cirrhosis of the liver, systolic and diastolic congestive heart failure.

A nurse's note, dated 12/9/24, indicated the resident's family was notified that the resident was being moved to another facility for a higher level of care on this date.

Documentation was lacking a Notice of Transfer/Discharge having been issued prior to the move on 12/9/24.

During an interview with the DON on 3/18/25 at 12:25 p.m., she indicated no Notice of Transfer/Discharge was issued

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

because the resident needed to move to a higher level of care.

The review of the Resident Service Agreement included, but was not limited to, "...E. Termination:...2. Termination By Us: a. Upon Thirty (30) Days' Notice. We may terminate this rental agreement and service agreement upon 30 days written notice to you and, if applicable, to your sponsor via certified mail... We shall also send a copy of such termination notice to the Department of Health....Notice of Termination: The written notice of termination shall include: (i) the reasons for the proposed discharge or transfer; (11) the proposed date of the discharge or transfer; (iii) the proposed location to which you will be transferred or discharged..."

Cross Reference R0048

This Citation relates to Complaint IN00454400.

Based on record review and interview, the facility failed to notify the State Agencies (Ombudsman, Adult Protective Services, Area Agency on Aging and State Department of Health) when one resident was issued a 30-day Notice of Transfer/Discharge (Resident D), and one resident was transferred to another facility without a 30-day Notice

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

(Resident F). This deficient practice affected 2 of 4 residents reviewed for discharge. (Resident D and F)

Findings include:

1. The record for Resident D was reviewed on 3/18/25 at 11:00 a.m. The resident's diagnoses included, but were not limited to, asthma, atrial fibrillation and flutter, chronic lymphocytic leukemia of B-Cell type, chronic obstructive pulmonary disease, mild cognitive impairment of uncertain or unknown etiology and

bipolar disorder.

On 1/10/25, Resident D was issued a 30-day Transfer/Discharge Notice from the facility due to failure to make rent payments each month after a reasonable amount of time and appropriate notice to pay.

The review of the letter that accompanied the notice indicated the Long Term Care Ombudsman, the State Department of Health, Adult Protective Services, and Agency on Aging were notified of the Transfer/Discharge Notice.

During an interview with the local Ombudsman on 3/18/25 at 9:56 a.m., she indicated she had not received a copy of the 30-Day Notice of

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

Transfer/Discharge for this resident. Her supervisor had not received the notice either when she checked with her.

During an interview with the Director of Nursing (DON), on 3/18/25 at 12:20 p.m., she indicated she was unable to provide any documentation to show the State agencies had been notified of the plan to discharge Resident D.

2. The record for Resident F was reviewed on 3/18/25 at 1:30 p.m. The resident's diagnoses included, but were not limited to, unspecified dementia without behavioral disturbance, psychotic disturbance, mood disturbance, anxiety, cirrhosis of the liver, systolic and diastolic congestive heart failure.

A nurse's note, dated 12/9/24, indicated the resident's family was notified that the resident was being moved to another facility for a higher level of care on this date.

Documentation was lacking a Notice of Transfer/Discharge having been issued prior to the move on 12/9/24.

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

	During an interview with the DON on 3/18/25 at 12:25 p.m., she indicated no Notice of Transfer/Discharge was issued because the resident needed to move to a higher level of care. The review of the Resident Service Agreement included, but was not limited to, "...E. Termination:...2. Termination By Us: a. Upon Thirty (30) Days' Notice. We may terminate this rental agreement and service agreement upon 30 days written notice to you and, if applicable, to your sponsor via certified mail... We shall also send a copy of such termination notice to the Department of Health....Notice of Termination: The written notice of termination shall include: (i) the reasons for the proposed discharge or transfer; (11) the proposed date of the discharge or transfer; (iii) the proposed location to which you will be transferred or discharged..." Cross Reference R0048 This Citation relates to Complaint IN00454400.			
R 0048	Residents' Rights - Deficiency 410 IAC 16.2-5-1.2(r)(18-24) (18) Prior to any interfacility or involuntary intrafacility relocation, the facility shall prepare a relocation plan to prepare the	R 0048	R0048- Resident Rights. It is the policy of Vivera of Jeffersonville to schedule a relocation meeting with the resident and/or family including the care team prior to the relocation of a	04/18/2025

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

resident for relocation and to provide continuity of care. In nonemergency relocations, the planning process shall include a relocation planning conference to which the resident, his or her legal representative, family members, and physician shall be invited. The planning conference may be waived by the resident.

(19) At the planning conference the resident ' s medical, psychosocial, and social needs with respect to the relocation shall be considered and a plan devised to meet these needs.

(20) The facility shall provide reasonable assistance to the resident to carry out the relocation plan.

(21) The facility must provide sufficient preparation and orientation to residents to ensure safe and orderly transfer or discharge from the facility.

(22) If the relocation plan is disputed, a meeting shall be held prior to the relocation with the administrator or his or her designee, the resident, and the resident ' s legal representative. An interested family member, if known, shall be invited. The purpose of the meeting shall be to discuss possible alternatives to the proposed relocation plan.

(23) A written report of the content of the discussion at the meeting and the results of the meeting shall be reviewed by:

(A) the administrator or his or her

resident when issued a 30 day notice to involuntary discharge. Resident D was offered a relocation hearing; the ombudsman refused the relocation hearing via email.

What corrective actions will be accomplished for those residents found to have been affected by the same practice:

Vivera Senior Living Jeffersonville will provide a 30-day notice to current residents that require skilled long term care. The community will follow the 30 day notice of discharge process and notify the appropriate state agencies.

How the facility will identify other residents having the potential to be affected by the same deficient practice:

all residents have the potential to be affected. The Executive Director or designee will give 30 day discharge notices to residents that require a higher level of care.

What measures will be put into place or what systemic changes will the facility make

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

designee;

(B) the resident;

(C) the resident ' s legal representative; and

(D) an interested family member, if known; each of whom may make written comments on the report.

(24) The written report of the meeting shall be included in the resident ' s permanent record.

Based on record review and interview, the facility failed to prepare a relocation plan to prepare the residents and families for relocation and continuity of care and did not provide sufficient preparation and orientation to the residents to ensure a safe and orderly transfer or discharge from the facility. This deficient practice affected 2 of 4 residents reviewed for Discharge. (Residents D and F)

Findings include:

to ensure that the deficient practice does not reoccur: By using the audit tool to track any 30 day discharges will ensure that the appropriate agencies are notified. The audit tool will be completed weekly for four weeks, then twice a month for three months then monthly thereafter.

How the corrective actions will be monitored to ensure the practice will not reoccur: the audit tool will be used to track any 30 day discharge notices.

The systematic changes will be completed by April 18th 2025.

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

1. The record for Resident D was reviewed on 3/18/25 at 11:00 a.m. The resident's diagnoses included, but were not limited to, asthma, atrial fibrillation and flutter, chronic lymphocytic leukemia of B-Cell type, chronic obstructive pulmonary disease, mild cognitive impairment of uncertain or unknown etiology and

bipolar disorder.

On 1/10/25, Resident D was issued a 30-day Transfer/Discharge Notice from the facility due to failure to make rent payments each month after a reasonable amount of time and appropriate notice to pay.

Documentation was lacking of the facility having prepared a relocation plan and discussed it with Resident D prior to the proposed date of discharge.

In an interview with the local Ombudsman on 3/18/25 at 9:56 a.m., she indicated that the resident did appeal the notice. The Executive Director (ED) informed the Administrative Law Judge (ALJ) that it was the corporation who decided the resident would be a good fit at the homeless shelter. The Ombudsman indicated the shelter listed on the notice was one that had to be contacted to see if they had room available

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

and if they thought the person would be a good fit there. When she contacted the shelter, she was informed they had not received a referral or a call from the facility on the resident.

During an interview with Resident D, on 3/18/25 at 11:10 a.m., he indicated he was unaware there was a problem with his rent not being paid and was very surprised when he received the 30-day notice. The resident was angry about the notice, especially the location where he was supposed to be transferred. He was never given a choice where he would be discharged to and did not believe the homeless shelter was an appropriate place to go to when discharged.

2. The record for Resident F was reviewed on 3/18/25 at 1:30 p.m. The resident's diagnoses included, but were not limited to, dementia without behavioral disturbance, psychotic disturbance, mood disturbance, anxiety, cirrhosis of the liver, systolic and diastolic congestive heart failure.

A nurse's note, dated 12/9/24, indicated the resident's family was notified the resident was being moved to another facility for a higher level of care on this date.

Documentation was lacking of a

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

relocation plan being developed in conjunction with the family and resident to prepare them for discharge; to discuss the resident's medical, psychosocial and social needs; to devise a plan to meet these needs; and sufficient orientation of preparation to be carried out to ensure a safe and orderly transfer from the facility.

Review of the Resident Service Agreement included, but was not limited to, "...TERMS AND OBLIGATIONS...D. Transfer for more Appropriate Care:...You may remain in your apartment as long as doing so is conducive to your safety and well-being...and applicable legal requirements. If we determine, in consultation with you, your family and/or your physician, that you are unable to remain in your apartment consistent with these requirements, you will be asked to move from the Community...Termination By Us...c. Referral Procedure: Within the 30-day notice, the community will work with the resident, their family, and case worker (if one is involved) to find appropriate housing and care. The community supports the resident's right to choose their own health care providers..."

Cross Reference R0045

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

This Citation relates to
Complaint IN00454400.

Based on record review and interview, the facility failed to prepare a relocation plan to prepare the residents and families for relocation and continuity of care and did not provide sufficient preparation and orientation to the residents to ensure a safe and orderly transfer or discharge from the facility. This deficient practice affected 2 of 4 residents reviewed for Discharge.
(Residents D and F)

Findings include:

1. The record for Resident D was reviewed on 3/18/25 at 11:00 a.m. The resident's diagnoses included, but were not limited to, asthma, atrial fibrillation and flutter, chronic lymphocytic leukemia of B-Cell type, chronic obstructive pulmonary disease, mild cognitive impairment of uncertain or unknown etiology and

bipolar disorder.

On 1/10/25, Resident D was issued a 30-day Transfer/Discharge Notice from the facility due to failure to make rent payments each month after a reasonable amount of time and appropriate notice to pay.

Documentation was lacking of

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

the facility having prepared a relocation plan and discussed it with Resident D prior to the proposed date of discharge.

In an interview with the local Ombudsman on 3/18/25 at 9:56 a.m., she indicated that the resident did appeal the notice. The Executive Director (ED) informed the Administrative Law Judge (ALJ) that it was the corporation who decided the resident would be a good fit at the homeless shelter. The Ombudsman indicated the shelter listed on the notice was one that had to be contacted to see if they had room available and if they thought the person would be a good fit there. When she contacted the shelter, she was informed they had not received a referral or a call from the facility on the resident.

During an interview with Resident D, on 3/18/25 at 11:10 a.m., he indicated he was unaware there was a problem with his rent not being paid and was very surprised when he received the 30-day notice. The resident was angry about the notice, especially the location where he was supposed to be transferred. He was never given a choice where he would be discharged to and did not believe the homeless shelter was an appropriate place to go to when discharged.

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

2. The record for Resident F was reviewed on 3/18/25 at 1:30 p.m. The resident's diagnoses included, but were not limited to, dementia without behavioral disturbance, psychotic disturbance, mood disturbance, anxiety, cirrhosis of the liver, systolic and diastolic congestive heart failure.

A nurse's note, dated 12/9/24, indicated the resident's family was notified the resident was being moved to another facility for a higher level of care on this date.

Documentation was lacking of a relocation plan being developed in conjunction with the family and resident to prepare them for discharge; to discuss the resident's medical, psychosocial and social needs; to devise a plan to meet these needs; and sufficient orientation of preparation to be carried out to ensure a safe and orderly transfer from the facility.

Review of the Resident Service Agreement included, but was not limited to, "...TERMS AND OBLIGATIONS...D. Transfer for more Appropriate Care:...You may remain in your apartment as long as doing so is conducive to your safety and well-being...and applicable legal requirements. If we determine, in consultation with you, your family and/or your physician,

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

	that you are unable to remain in your apartment consistent with these requirements, you will be asked to move from the Community...Termination By Us...c. Referral Procedure: Within the 30-day notice, the community will work with the resident, their family, and case worker (if one is involved) to find appropriate housing and care. The community supports the resident's right to choose their own health care providers..." Cross Reference R0045 This Citation relates to Complaint IN00454400.			
R 0349	Clinical Records - Noncompliance 410 IAC 16.2-5-8.1(a)(1-4) (a) The facility must maintain clinical records on each resident. These records must be maintained under the supervision of an employee of the facility designated with that responsibility. The records must be as follows: (1) Complete. (2) Accurately documented. (3) Readily accessible. (4) Systematically organized. 2. The Communication note with the family, dated 1/10/25 at 12:15 p.m., indicated staff notified the family member of	R 0349	R 349. Clinical documentation. It is the procedure of Vivera Senior Living of Jeffersonville to maintain accurate clinical records on each resident. What Corrective actions will be accomplished for those residents found to have been affected by the deficient practices: Documentation for all residents on leave of absence will be accurate. Notes will reflect residents on leave of absence or death. All nursing staff will be educated on proper leave of absence	04/18/2025

Resident G's death. The family member wished to contact the rest of the family. The funeral home was contacted per the resident's wishes. The funeral home arrived to transport the resident's body. The coroner's office was contacted, and they indicated they did not need to be notified but would assist the family as needed.

Resident G's record was reviewed on 3/18/25. The record documentation indicated the following:

- The Administration note, dated 1/10/25 at 5:03 p.m., indicated the resident's Wellness Assessment for Medicaid was completed every day shift. The resident passed away.

- The Administration note, dated 1/13/25 at 2:27 p.m., indicated the resident's Wellness Assessment for Medicaid was completed every day shift. The resident passed away.

- The Administration note, dated 1/14/25 at 4:51 p.m., indicated the resident's 4-hour safety check was conducted. The resident was deceased.

- The Administration note, dated 1/14/25 at 9:13 p.m., indicated the resident's 4-hour safety check was conducted. The resident passed away 1/10/25.

- The Administration note, dated

documentation
by April 18th 2025.

How the facility will identify other residents having the potential to be affected by the same deficient practice: All residents on leave of absence have the potential to be affected. All leave of absence residents will be audited by DON or designee to ensure accuracy. See audit tool named weekly LOA audit.

What measures will be put into place or what systemic changes

will the facility make to ensure that the deficient practice does not recur. Documentation for those residents on Leave of absence will be audited weekly by DON or designee, to ensure compliance is maintained. This audit tool will be ongoing.

How the corrective actions will be monitored to ensure the deficient practice will not recur.

DON or designee will audit

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

1/15/25 at 3: p.m., indicated the resident's Wellness Assessment for Medicaid was completed every day shift. The resident passed away.

- The Administration note, dated 1/17/25 at 4:53 p.m., indicated the resident was hospitalized.

- The Administration note, dated 1/17/25 at 11:39 p.m., indicated the resident's 4-hour safety check was conducted. The resident was deceased.

- The Administration note, dated 1/18/25 at 3:00 a.m., indicated the resident's 4-hour safety check was conducted.

- The Administration note, dated 1/18/25 at 12:15 p.m., indicated the resident's Wellness Assessment for Medicaid was completed every day shift. The resident passed away.

- The Administration note, dated 1/22/25 at 11:25 p.m., indicated the resident's 4-hour safety check was conducted.

- The Administration note, dated 1/23/25 at 3:02 a.m., indicated the resident's 4-hour safety check was conducted.

charts for those residents on leave of absence weekly to ensure accurate documentation. Further monitoring will be discussed in monthly QA committee to determine further action as necessary.

By what date the systematic changes will be completed.

April 18th 2025

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

- The Administration note, dated 1/23/25 at 10:44 a.m., indicated the resident's Wellness Assessment for Medicaid was completed every day shift. The resident passed away.

- The Administration note, dated 1/24/25 at 1:50 a.m., indicated the resident's 4-hour safety check was conducted. The resident was expired.

- The Administration note, dated 1/24/25 at 1:46 p.m., indicated the resident's Wellness Assessment for Medicaid was completed every day shift. The resident passed away.

- The Administration note, dated 1/25/25 at 3:32 p.m., indicated the resident's Wellness Assessment for Medicaid was completed every day shift. The resident was deceased.

- The Administration note, dated 1/26/25 at 1:16 a.m., indicated the resident's 4-hour safety check was conducted.

- The Administration note, dated 1/26/25 at 1:41 p.m., indicated the resident's Wellness Assessment for Medicaid was completed every day shift. The resident was deceased.

- The Administration note, dated 1/27/25 at 10:46 a.m., indicated the resident's Wellness Assessment for Medicaid was completed every day shift. The

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

resident was passed.

- The Administration note, dated 1/28/25 at 1:43 p.m., indicated the resident's Wellness Assessment for Medicaid was completed every day shift. The resident was expired.

3. The nurse's note, dated 2/5/25 at 12:35 p.m., indicated the nurse was alerted by a Qualified Medication Aide (QMA) that Resident J had no pulse or breathing. The nurse went to the resident's room with a second nurse, and two nurses verified that the resident had no heartbeat or respirations. The time of death was 2/5/25 at 8:25 a.m. Family was at bedside. A call was placed to hospice, the Nurse Practitioner (NP), DON, and Assistant Director of Nursing (ADON). The resident's remains were picked up by the funeral home at 10:55 a.m.

Resident J's record was reviewed on 3/18/25. The record documentation indicated the following:

- The Administration note, dated 2/5/25 at 8:15 p.m., indicated that if the resident has to be sent to the hospital for any reason per the Power of Attorney (POA); she was only to go to two local hospitals, two times a day for the medical decision.

- The Administration note, dated

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

2/8/25 at 9:30 p.m., indicated the resident was on leave.

- The Administration note, dated 2/18/25 at 10:07 a.m., indicated if the resident had to be sent to the hospital for any reason per POA; she was only to go to two local hospitals, two times a day for medical decision.

- The Administration note, dated 2/19/25 at 8:11 a.m., indicated the resident was LOA.

- The Administration note, dated 2/19/25 at 8:19 p.m., indicated the resident was on leave.

- The Administration note, dated 2/21/25 at 9:45 p.m., indicated the resident was on leave.

- The Administration note, dated 2/22/25 at 9:58 a.m., indicated if the resident had to be sent to the hospital for any reason per POA; she was only to go to two local hospitals, two times a day for medical decision. The resident was deceased.

- The Administration note, dated 2/22/25 9:01 p.m., indicated the resident was on leave.

- The Administration note, dated 2/23/25 at 9:32 p.m., indicated the resident was on leave.

- The Administration note, dated 2/26/25 at 8:14 a.m., indicated the resident was LOA.

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

- The Administration note, dated 2/26/25 at 4:22 p.m., indicated the resident was absent.
- The Administration note, dated 2/28/25 at 8:45 p.m., indicated the resident was on leave.
- The Administration note, dated 3/1/25 at 8:58 a.m., indicated the resident was LOA.
- The Administration note, dated 3/2/25 at 9:10 a.m., indicated the resident was LOA.
- The Administration note, dated 3/3/25 at 9:59 a.m., indicated if resident has to be sent to the hospital for any reason per POA; she was only to go to two local hospitals, two times a day for medical decision.
- The Administration note, dated 3/3/25 at 10:17 p.m., indicated the resident was on leave.
- The Administration note, dated 3/4/25 at 4:29 p.m., indicated the resident was absent from home with or without medications (AW).
- The Administration note, dated 3/5/25 at 8:58 a.m., indicated the resident was LOA.
- The Administration note, dated 3/5/25 at 10:23 p.m., indicated the resident was on leave.
- The Administration note, dated 3/7/25 at 9:02 a.m., indicated

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

the resident was LOA.

During an e-mail sent on 3/18/25 at 1:43 p.m., the Regional Compliance Officer, failed to respond to the e-mail regarding information concerning documentation and billing.

During an interview, on 3/18/25 at 2:27 p.m., the DON indicated the IHCC documentation could not be taken out of the system for Medicaid. The corporate office would not let them remove the documentation from the notes.

An e-mail was sent, on 3/18/25 at 1:43 p.m., to the Regional Compliance Officer related to documentation and billing. Regional Compliance Officer 51 failed to respond to the enquirer.

Based on record review and interview, the facility failed to ensure accurate documentation for 4 of 9 deceased or discharged residents.
(Residents H, G, J, B)

Findings Include:

1. The nurse's note, dated 3/5/25 at 8:50 a.m., indicated Resident H was observed not to be in the dining room for breakfast. A wellness check was initiated. Upon arriving at the resident's room, he was found on the bathroom floor, face

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

down, unconscious, no pulse present, stiff blue extremities, and he was cold to touch. The nurse called the Assistant Director of Nursing (ADON) for assistance. No extraordinary measures were taken due to residents' DO NOT Resuscitate (DNR) code status. A call was made to emergency services system (EMS) and EMS pronounced the time of death at 8:50 am. The DON (Director of Nursing) contacted the family and the funeral home services.

Resident H's record was reviewed on 3/18/25. The record documentation indicated the following:

- The health status note, dated 3/5/25 at 10:27 a.m., indicated staff met with therapy to discuss the resident's participation and progress yesterday. The resident completed 60 minutes of Occupational Therapy (OT) without issue. Will continue to follow progress.

- The Administration note, dated 3/6/25 at 7:44 a.m., indicated the resident was AW (away without medications).

- The Administration note, dated 3/6/25 at 3:15 p.m., indicated the resident was AW

- The Administration note, dated 3/8/25 at 11:26 a.m., indicated for Resident H a Wellness Assessment for Medicaid was

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

completed everyday shift.

- The Administration note, dated 3/9/25 at 9:02 p.m., indicated the resident was loa (leave of absence).

During an interview, on 3/18/25 at 1:30 p.m., a phone call was made to the Administrative Billing in the cooperate office to inquire about their policy regarding documentation and billing after a death or discharge. The facility office manager indicated the number and name of who to contact for the administrative billing cooperate office. During the multiple attempts to contact the cooperate office, Corperate Staff Member 50, indicated she was unwilling to talk.

4. The record for Resident B was reviewed on 3/18/25 at 11:00 a.m. The resident's diagnoses included, but were not limited to, diabetes mellitus with diabetic chronic kidney disease, hemiplegia and hemiparesis following cerebral infarction affecting the resident's non-dominant side, polyneuropathy, chronic pain syndrome and occlusion and stenosis of bilateral carotid arteries.

The medication administration record (MAR) documentation indicated the resident self-medicated during the time

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

frame of 2/18/25 to 3/18/25. The resident expired on 2/18/25.

During an interview, on 3/18/25 at 12:50 p.m., the resident's family member and POA indicated that the resident did expire on 2/18/25 and could not have taken her medications unsupervised through the month of February and March.

A physician's order, dated 6/18/24, indicated the staff were to provide the resident assistance with self-administration of oral and special medications.

A physician's order, dated 6/19/24, indicated that the resident was to have Aspirin 325mg (Milligram) by mouth one time a day related to her diagnosis of the occlusion and stenosis of her bilateral carotid arteries. The medication could be taken by the resident as an unsupervised medication.

The Service Plan, dated 6/26/24, indicated that the resident had a clear understanding of medications, purpose, dose and indication for her prescriptions. The resident was independent and could self-administer her medications unsupervised by nursing staff.

A nurse's note, dated 2/18/25 at 9:20 a.m., indicated the nursing staff responded to a call for assistance from a Certified

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

Nurse Aide (CNA). At 8:43 a.m., resident was in bed, without breathing apparent, and was unresponsive to verbal or physical stimuli. No pulse was found, the resident was cold to the touch, and cardiopulmonary resuscitation (CPR) was started at 8:45 a.m. Emergency Medical Services (EMS) arrived at the facility at 8:52 a.m. and took charge in the resuscitation efforts. At 8:54 a.m., the resident was declared deceased by EMS and the family was notified.

Resident B's record was reviewed on 3/18/25. The record documentation indicated the following:

- A nurse's note, dated 2/18/25 at 10:25 a.m., indicated the family was currently at the resident's bedside and staff were awaiting instructions for funeral arrangements.

- An administration noted, dated 2/23/25 at 9:05 a.m., indicated the resident was on a leave of absence. The resident was deceased on 2/18/25.

- An administration noted, dated 2/27/25 at 2:42 p.m., indicated the resident was on a leave of absence. The resident was deceased on 2/18/25.

- An administration noted, dated 2/28/25 at 9:36 a.m., indicated the resident was on a leave of

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

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OMB NO. 0938-0391

absence. The resident was deceased on 2/18/25.

- An administration note, dated 3/1/2025 on 9:46 a.m., indicated the resident was monitored due to antidepressant medication. The nursing staff were to monitor for sedation, drowsiness, dry mouth, blurred vision, urinary retention, tachycardia, muscle tremors, agitation, headache, skin rash, photosensitivity (skin) excess weight gain. The staff were to document: the letter 'Y' if the resident was monitored and none of the above signs or symptoms were observed. The letter 'N' was documented if the resident was monitored and any of the above was signs and symptoms were observed. The staff would then document accurately in the 'Other/ See Nurses Notes' findings. This was ordered to be completed two times a day for anti-depressant monitoring. This administrative note lacked the explanation of why the letter 'N' was documented. The resident was deceased on 2/18/25.

- An Administration note, dated 3/2/2025 on 9: 57 a.m., indicated the resident was being monitored for anticoagulant medication (blood thinning medication). The nursing staff were to monitor the resident for discolored urine, black tarry stools, sudden severe

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

headache, nausea & vomiting, diarrhea, muscle joint pain, lethargy, bruising, sudden changes in mental status and/ or v/s, sob, nose bleeds. The staff were to document: the letter 'Y' if the resident was monitored and none of the above signs or symptoms were observed. The letter 'N' was documented if the resident were monitored and any of the above was signs and symptoms were observed. The staff would then document accurately in the 'Other/ See Nurses Notes' findings. This was ordered to be completed two times a day for anticoagulation therapy monitoring. This administrative note lacked the explanation of why the letter 'N' was documented. The resident was deceased on 2/18/25.

- An Administration note, dated 3/3/2025 at 10:52 a.m., indicated the resident was deceased. The resident expired on 2/18/25.

- An Administration note, dated 3/3/2025 at 11:36 p.m., indicated the resident was on leave. The resident expired on 2/18/25

- An Administration note, dated 3/2/2025 at 1:40 p.m., indicated that an order was renewed for a full set of vitals and weight obtained, starting on the second day of each month. The resident

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

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OMB NO. 0938-0391

was deceased on 2/18/25.

On 3/18/25, no policies on documentation were presented.

This Citation relates to Complaint IN00454400.

2. The Communication note with the family, dated 1/10/25 at 12:15 p.m., indicated staff notified the family member of Resident G's death. The family member wished to contact the rest of the family. The funeral home was contacted per the resident's wishes. The funeral home arrived to transport the resident's body. The coroner's office was contacted, and they indicated they did not need to be notified but would assist the family as needed.

Resident G's record was reviewed on 3/18/25. The record documentation indicated the following:

- The Administration note, dated 1/10/25 at 5:03 p.m., indicated the resident's Wellness Assessment for Medicaid was completed every day shift. The resident passed away.

- The Administration note, dated 1/13/25 at 2:27 p.m., indicated the resident's Wellness Assessment for Medicaid was completed every day shift. The resident passed away.

- The Administration note, dated

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

1/14/25 at 4:51 p.m., indicated the resident's 4-hour safety check was conducted. The resident was deceased.

- The Administration note, dated 1/14/25 at 9:13 p.m., indicated the resident's 4-hour safety check was conducted. The resident passed away 1/10/25.

- The Administration note, dated 1/15/25 at 3: p.m., indicated the resident's Wellness Assessment for Medicaid was completed every day shift. The resident passed away.

- The Administration note, dated 1/17/25 at 4:53 p.m., indicated the resident was hospitalized.

- The Administration note, dated 1/17/25 at 11:39 p.m., indicated the resident's 4-hour safety check was conducted. The resident was deceased.

- The Administration note, dated 1/18/25 at 3:00 a.m., indicated the resident's 4-hour safety check was conducted.

- The Administration note, dated 1/18/25 at 12:15 p.m., indicated the resident's Wellness Assessment for Medicaid was completed every day shift. The resident passed away.

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

FORM APPROVED

OMB NO. 0938-0391

- | | | | |
|---|--|--|--|
| <ul style="list-style-type: none">- The Administration note, dated 1/22/25 at 11:25 p.m., indicated the resident's 4-hour safety check was conducted.- The Administration note, dated 1/23/25 at 3:02 a.m., indicated the resident's 4-hour safety check was conducted.- The Administration note, dated 1/23/25 at 10:44 a.m., indicated the resident's Wellness Assessment for Medicaid was completed every day shift. The resident passed away.- The Administration note, dated 1/24/25 at 1:50 a.m., indicated the resident's 4-hour safety check was conducted. The resident was expired.- The Administration note, dated 1/24/25 at 1:46 p.m., indicated the resident's Wellness Assessment for Medicaid was completed every day shift. The resident passed away.- The Administration note, dated 1/25/25 at 3:32 p.m., indicated the resident's Wellness Assessment for Medicaid was completed every day shift. The resident was deceased.- The Administration note, dated 1/26/25 at 1:16 a.m., indicated the resident's 4-hour safety check was conducted.- The Administration note, dated 1/26/25 at 1:41 p.m., indicated | | | |
|---|--|--|--|

the resident's Wellness Assessment for Medicaid was completed every day shift. The resident was deceased.

- The Administration note, dated 1/27/25 at 10:46 a.m., indicated the resident's Wellness Assessment for Medicaid was completed every day shift. The resident was passed.

- The Administration note, dated 1/28/25 at 1:43 p.m., indicated the resident's Wellness Assessment for Medicaid was completed every day shift. The resident was expired.

3. The nurse's note, dated 2/5/25 at 12:35 p.m., indicated the nurse was alerted by a Qualified Medication Aide (QMA) that Resident J had no pulse or breathing. The nurse went to the resident's room with a second nurse, and two nurses verified that the resident had no heartbeat or respirations. The time of death was 2/5/25 at 8:25 a.m. Family was at bedside. A call was placed to hospice, the Nurse Practitioner (NP), DON, and Assistant Director of Nursing (ADON). The resident's remains were picked up by the funeral home at 10:55 a.m.

Resident J's record was reviewed on 3/18/25. The record documentation indicated the following:

- The Administration note, dated

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

2/5/25 at 8:15 p.m., indicated that if the resident has to be sent to the hospital for any reason per the Power of Attorney (POA); she was only to go to two local hospitals, two times a day for the medical decision.

- The Administration note, dated 2/8/25 at 9:30 p.m., indicated the resident was on leave.

- The Administration note, dated 2/18/25 at 10:07 a.m., indicated if the resident had to be sent to the hospital for any reason per POA; she was only to go to two local hospitals, two times a day for medical decision.

- The Administration note, dated 2/19/25 at 8:11 a.m., indicated the resident was LOA.

- The Administration note, dated 2/19/25 at 8:19 p.m., indicated the resident was on leave.

- The Administration note, dated 2/21/25 at 9:45 p.m., indicated the resident was on leave.

- The Administration note, dated 2/22/25 at 9:58 a.m., indicated if the resident had to be sent to the hospital for any reason per POA; she was only to go to two local hospitals, two times a day for medical decision. The resident was deceased.

- The Administration note, dated 2/22/25 9:01 p.m., indicated the

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

resident was on leave.

- The Administration note, dated 2/23/25 at 9:32 p.m., indicated the resident was on leave.

- The Administration note, dated 2/26/25 at 8:14 a.m., indicated the resident was LOA.

- The Administration note, dated 2/26/25 at 4:22 p.m., indicated the resident was absent.

- The Administration note, dated 2/28/25 at 8:45 p.m., indicated the resident was on leave.

- The Administration note, dated 3/1/25 at 8:58 a.m., indicated the resident was LOA.

- The Administration note, dated 3/2/25 at 9:10 a.m., indicated the resident was LOA.

- The Administration note, dated 3/3/25 at 9:59 a.m., indicated if resident has to be sent to the hospital for any reason per POA; she was only to go to two local hospitals, two times a day for medical decision.

- The Administration note, dated 3/3/25 at 10:17 p.m., indicated the resident was on leave.

- The Administration note, dated 3/4/25 at 4:29 p.m., indicated the resident was absent from home with or without medications (AW).

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

- The Administration note, dated 3/5/25 at 8:58 a.m., indicated the resident was LOA.

- The Administration note, dated 3/5/25 at 10:23 p.m., indicated the resident was on leave.

- The Administration note, dated 3/7/25 at 9:02 a.m., indicated the resident was LOA.

During an e-mail sent on 3/18/25 at 1:43 p.m., the Regional Compliance Officer, failed to respond to the e-mail regarding information concerning documentation and billing.

During an interview, on 3/18/25 at 2:27 p.m., the DON indicated the IHCC documentation could not be taken out of the system for Medicaid. The corporate office would not let them remove the documentation from the notes.

An e-mail was sent, on 3/18/25 at 1:43 p.m., to the Regional Compliance Officer related to documentation and billing. Regional Compliance Officer 51 failed to respond to the enquirer.

Based on record review and interview, the facility failed to ensure accurate documentation for 4 of 9 deceased or discharged residents.
(Residents H, G, J, B)

Findings Include:

1. The nurse's note, dated 3/5/25 at 8:50 a.m., indicated Resident H was observed not to be in the dining room for breakfast. A wellness check was initiated. Upon arriving at the resident's room, he was found on the bathroom floor, face down, unconscious, no pulse present, stiff blue extremities, and he was cold to touch. The nurse called the Assistant Director of Nursing (ADON) for assistance. No extraordinary measures were taken due to residents' DO NOT Resuscitate (DNR) code status. A call was made to emergency services system (EMS) and EMS pronounced the time of death at 8:50 am. The DON (Director of Nursing) contacted the family and the funeral home services.

Resident H's record was reviewed on 3/18/25. The record documentation indicated the following:

- The health status note, dated 3/5/25 at 10:27 a.m., indicated staff met with therapy to discuss the resident's participation and progress yesterday. The resident completed 60 minutes of Occupational Therapy (OT) without issue. Will continue to follow progress.

- The Administration note, dated 3/6/25 at 7:44 a.m., indicated

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

the resident was AW (away without medications).

- The Administration note, dated 3/6/25 at 3:15 p.m., indicated the resident was AW

- The Administration note, dated 3/8/25 at 11:26 a.m., indicated for Resident H a Wellness Assessment for Medicaid was completed everyday shift.

- The Administration note, dated 3/9/25 at 9:02 p.m., indicated the resident was loa (leave of absence).

During an interview, on 3/18/25 at 1:30 p.m., a phone call was made to the Administrative Billing in the cooperate office to inquire about their policy regarding documentation and billing after a death or discharge. The facility office manager indicated the number and name of who to contact for the administrative billing cooperate office. During the multiple attempts to contact the cooperate office, Corperate Staff Member 50, indicated she was unwilling to talk.

4. The record for Resident B was reviewed on 3/18/25 at 11:00 a.m. The resident's diagnoses included, but were not limited to, diabetes mellitus with diabetic chronic kidney disease, hemiplegia and hemiparesis following cerebral infarction affecting the resident's

non-dominant side, polyneuropathy, chronic pain syndrome and occlusion and stenosis of bilateral carotid arteries.

The medication administration record (MAR) documentation indicated the resident self-medicated during the time frame of 2/18/25 to 3/18/25. The resident expired on 2/18/25.

During an interview, on 3/18/25 at 12:50 p.m., the resident's family member and POA indicated that the resident did expire on 2/18/25 and could not have taken her medications unsupervised through the month of February and March.

A physician's order, dated 6/18/24, indicated the staff were to provide the resident assistance with self-administration of oral and special medications.

A physician's order, dated 6/19/24, indicated that the resident was to have Aspirin 325mg (Milligram) by mouth one time a day related to her diagnosis of the occlusion and stenosis of her bilateral carotid arteries. The medication could be taken by the resident as an unsupervised medication.

The Service Plan, dated 6/26/24, indicated that the resident had a clear understanding of medications,

purpose, dose and indication for her prescriptions. The resident was independent and could self-administer her medications unsupervised by nursing staff.

A nurse's note, dated 2/18/25 at 9:20 a.m., indicated the nursing staff responded to a call for assistance from a Certified Nurse Aide (CNA). At 8:43 a.m., resident was in bed, without breathing apparent, and was unresponsive to verbal or physical stimuli. No pulse was found, the resident was cold to the touch, and cardiopulmonary resuscitation (CPR) was started at 8:45 a.m. Emergency Medical Services (EMS) arrived at the facility at 8:52 a.m. and took charge in the resuscitation efforts. At 8:54 a.m., the resident was declared deceased by EMS and the family was notified.

Resident B's record was reviewed on 3/18/25. The record documentation indicated the following:

- A nurse's note, dated 2/18/25 at 10:25 a.m., indicated the family was currently at the resident's bedside and staff were awaiting instructions for funeral arrangements.

- An administration noted, dated 2/23/25 at 9:05 a.m., indicated the resident was on a leave of absence. The resident was

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

deceased on 2/18/25.

- An administration noted, dated 2/27/25 at 2:42 p.m., indicated the resident was on a leave of absence. The resident was deceased on 2/18/25.

- An administration noted, dated 2/28/25 at 9:36 a.m., indicated the resident was on a leave of absence. The resident was deceased on 2/18/25.

- An administration note, dated 3/1/2025 on 9:46 a.m., indicated the resident was monitored due to antidepressant medication. The nursing staff were to monitor for sedation, drowsiness, dry mouth, blurred vision, urinary retention, tachycardia, muscle tremors, agitation, headache, skin rash, photosensitivity (skin) excess weight gain. The staff were to document: the letter 'Y' if the resident was monitored and none of the above signs or symptoms were observed. The letter 'N' was documented if the resident was monitored and any of the above was signs and symptoms were observed. The staff would then document accurately in the 'Other/ See Nurses Notes' findings. This was ordered to be completed two times a day for anti-depressant monitoring. This administrative note lacked the explanation of why the letter 'N' was documented. The resident

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

was deceased on 2/18/25.

- An Administration note, dated 3/2/2025 on 9: 57 a.m., indicated the resident was being monitored for anticoagulant medication (blood thinning medication). The nursing staff were to monitor the resident for discolored urine, black tarry stools, sudden severe headache, nausea & vomiting, diarrhea, muscle joint pain, lethargy, bruising, sudden changes in mental status and/ or v/s, sob, nose bleeds. The staff were to document: the letter 'Y' if the resident was monitored and none of the above signs or symptoms were observed. The letter 'N' was documented if the resident were monitored and any of the above was signs and symptoms were observed. The staff would then document accurately in the 'Other/ See Nurses Notes' findings. This was ordered to be completed two times a day for anticoagulation therapy monitoring. This administrative note lacked the explanation of why the letter 'N' was documented. The resident was deceased on 2/18/25.

- An Administration note, dated 3/3/2025 at 10:52 a.m., indicated the resident was deceased. The resident expired on 2/18/25.

- An Administration note, dated

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

3/3/2025 at 11:36 p.m., indicated the resident was on leave. The resident expired on 2/18/25

- An Administration note, dated 3/2/2025 at 1:40 p.m., indicated that an order was renewed for a full set of vitals and weight obtained, starting on the second day of each month. The resident was deceased on 2/18/25.

On 3/18/25, no policies on documentation were presented.

This Citation relates to Complaint IN00454400.

2. The Communication note with the family, dated 1/10/25 at 12:15 p.m., indicated staff notified the family member of Resident G's death. The family member wished to contact the rest of the family. The funeral home was contacted per the resident's wishes. The funeral home arrived to transport the resident's body. The coroner's office was contacted, and they indicated they did not need to be notified but would assist the family as needed.

Resident G's record was reviewed on 3/18/25. The record documentation indicated the following:

- The Administration note, dated 1/10/25 at 5:03 p.m., indicated the resident's Wellness Assessment for Medicaid was

completed every day shift. The resident passed away.

- The Administration note, dated 1/13/25 at 2:27 p.m., indicated the resident's Wellness Assessment for Medicaid was completed every day shift. The resident passed away.

- The Administration note, dated 1/14/25 at 4:51 p.m., indicated the resident's 4-hour safety check was conducted. The resident was deceased.

- The Administration note, dated 1/14/25 at 9:13 p.m., indicated the resident's 4-hour safety check was conducted. The resident passed away 1/10/25.

- The Administration note, dated 1/15/25 at 3: p.m., indicated the resident's Wellness Assessment for Medicaid was completed every day shift. The resident passed away.

- The Administration note, dated 1/17/25 at 4:53 p.m., indicated the resident was hospitalized.

- The Administration note, dated 1/17/25 at 11:39 p.m., indicated the resident's 4-hour safety check was conducted. The resident was deceased.

- The Administration note, dated 1/18/25 at 3:00 a.m., indicated the resident's 4-hour safety check was conducted.

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

- The Administration note, dated 1/18/25 at 12:15 p.m., indicated the resident's Wellness Assessment for Medicaid was completed every day shift. The resident passed away.

- The Administration note, dated 1/22/25 at 11:25 p.m., indicated the resident's 4-hour safety check was conducted.

- The Administration note, dated 1/23/25 at 3:02 a.m., indicated the resident's 4-hour safety check was conducted.

- The Administration note, dated 1/23/25 at 10:44 a.m., indicated the resident's Wellness Assessment for Medicaid was completed every day shift. The resident passed away.

- The Administration note, dated 1/24/25 at 1:50 a.m., indicated the resident's 4-hour safety check was conducted. The resident was expired.

- The Administration note, dated 1/24/25 at 1:46 p.m., indicated the resident's Wellness Assessment for Medicaid was completed every day shift. The resident passed away.

- The Administration note, dated 1/25/25 at 3:32 p.m., indicated the resident's Wellness Assessment for Medicaid was completed every day shift. The resident was deceased.

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

- The Administration note, dated 1/26/25 at 1:16 a.m., indicated the resident's 4-hour safety check was conducted.

- The Administration note, dated 1/26/25 at 1:41 p.m., indicated the resident's Wellness Assessment for Medicaid was completed every day shift. The resident was deceased.

- The Administration note, dated 1/27/25 at 10:46 a.m., indicated the resident's Wellness Assessment for Medicaid was completed every day shift. The resident was passed.

- The Administration note, dated 1/28/25 at 1:43 p.m., indicated the resident's Wellness Assessment for Medicaid was completed every day shift. The resident was expired.

3. The nurse's note, dated 2/5/25 at 12:35 p.m., indicated the nurse was alerted by a Qualified Medication Aide (QMA) that Resident J had no pulse or breathing. The nurse went to the resident's room with a second nurse, and two nurses verified that the resident had no heartbeat or respirations. The time of death was 2/5/25 at 8:25 a.m. Family was at bedside. A call was placed to hospice, the Nurse Practitioner (NP), DON, and Assistant Director of Nursing (ADON). The resident's remains were picked up by the

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

funeral home at 10:55 a.m.

Resident J's record was reviewed on 3/18/25. The record documentation indicated the following:

- The Administration note, dated 2/5/25 at 8:15 p.m., indicated that if the resident has to be sent to the hospital for any reason per the Power of Attorney (POA); she was only to go to two local hospitals, two times a day for the medical decision.

- The Administration note, dated 2/8/25 at 9:30 p.m., indicated the resident was on leave.

- The Administration note, dated 2/18/25 at 10:07 a.m., indicated if the resident had to be sent to the hospital for any reason per POA; she was only to go to two local hospitals, two times a day for medical decision.

- The Administration note, dated 2/19/25 at 8:11 a.m., indicated the resident was LOA.

- The Administration note, dated 2/19/25 at 8:19 p.m., indicated the resident was on leave.

- The Administration note, dated 2/21/25 at 9:45 p.m., indicated the resident was on leave.

- The Administration note, dated 2/22/25 at 9:58 a.m., indicated if the resident had to be sent to

the hospital for any reason per POA; she was only to go to two local hospitals, two times a day for medical decision. The resident was deceased.

- The Administration note, dated 2/22/25 9:01 p.m., indicated the resident was on leave.

- The Administration note, dated 2/23/25 at 9:32 p.m., indicated the resident was on leave.

- The Administration note, dated 2/26/25 at 8:14 a.m., indicated the resident was LOA.

- The Administration note, dated 2/26/25 at 4:22 p.m., indicated the resident was absent.

- The Administration note, dated 2/28/25 at 8:45 p.m., indicated the resident was on leave.

- The Administration note, dated 3/1/25 at 8:58 a.m., indicated the resident was LOA.

- The Administration note, dated 3/2/25 at 9:10 a.m., indicated the resident was LOA.

- The Administration note, dated 3/3/25 at 9:59 a.m., indicated if resident has to be sent to the hospital for any reason per POA; she was only to go to two local hospitals, two times a day for medical decision.

- The Administration note, dated 3/3/25 at 10:17 p.m., indicated

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

the resident was on leave.

- The Administration note, dated 3/4/25 at 4:29 p.m., indicated the resident was absent from home with or without medications (AW).

- The Administration note, dated 3/5/25 at 8:58 a.m., indicated the resident was LOA.

- The Administration note, dated 3/5/25 at 10:23 p.m., indicated the resident was on leave.

- The Administration note, dated 3/7/25 at 9:02 a.m., indicated the resident was LOA.

During an e-mail sent on 3/18/25 at 1:43 p.m., the Regional Compliance Officer, failed to respond to the e-mail regarding information concerning documentation and billing.

During an interview, on 3/18/25 at 2:27 p.m., the DON indicated the IHCC documentation could not be taken out of the system for Medicaid. The corporate office would not let them remove the documentation from the notes.

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

An e-mail was sent, on 3/18/25 at 1:43 p.m., to the Regional Compliance Officer related to documentation and billing. Regional Compliance Officer 51 failed to respond to the enquirer.

Based on record review and interview, the facility failed to ensure accurate documentation for 4 of 9 deceased or discharged residents. (Residents H, G, J, B)

Findings Include:

1. The nurse's note, dated 3/5/25 at 8:50 a.m., indicated Resident H was observed not to be in the dining room for breakfast. A wellness check was initiated. Upon arriving at the resident's room, he was found on the bathroom floor, face down, unconscious, no pulse present, stiff blue extremities, and he was cold to touch. The nurse called the Assistant Director of Nursing (ADON) for assistance. No extraordinary measures were taken due to residents' DO NOT Resuscitate (DNR) code status. A call was made to emergency services system (EMS) and EMS pronounced the time of death at 8:50 am. The DON (Director of Nursing) contacted the family and the funeral home services.

Resident H's record was reviewed on 3/18/25. The record

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

documentation indicated the following:

- The health status note, dated 3/5/25 at 10:27 a.m., indicated staff met with therapy to discuss the resident's participation and progress yesterday. The resident completed 60 minutes of Occupational Therapy (OT) without issue. Will continue to follow progress.

- The Administration note, dated 3/6/25 at 7:44 a.m., indicated the resident was AW (away without medications).

- The Administration note, dated 3/6/25 at 3:15 p.m., indicated the resident was AW

- The Administration note, dated 3/8/25 at 11:26 a.m., indicated for Resident H a Wellness Assessment for Medicaid was completed everyday shift.

- The Administration note, dated 3/9/25 at 9:02 p.m., indicated the resident was loa (leave of absence).

During an interview, on 3/18/25 at 1:30 p.m., a phone call was made to the Administrative Billing in the cooperate office to inquire about their policy regarding documentation and billing after a death or discharge. The facility office manager indicated the number and name of who to contact for the administrative billing

corporate office. During the multiple attempts to contact the corporate office, Corporate Staff Member 50, indicated she was unwilling to talk.

4. The record for Resident B was reviewed on 3/18/25 at 11:00 a.m. The resident's diagnoses included, but were not limited to, diabetes mellitus with diabetic chronic kidney disease, hemiplegia and hemiparesis following cerebral infarction affecting the resident's non-dominant side, polyneuropathy, chronic pain syndrome and occlusion and stenosis of bilateral carotid arteries.

The medication administration record (MAR) documentation indicated the resident self-medicated during the time frame of 2/18/25 to 3/18/25. The resident expired on 2/18/25.

During an interview, on 3/18/25 at 12:50 p.m., the resident's family member and POA indicated that the resident did expire on 2/18/25 and could not have taken her medications unsupervised through the month of February and March.

A physician's order, dated 6/18/24, indicated the staff were to provide the resident assistance with self-administration of oral and special medications.

A physician's order, dated 6/19/24, indicated that the resident was to have Aspirin 325mg (Milligram) by mouth one time a day related to her diagnosis of the occlusion and stenosis of her bilateral carotid arteries. The medication could be taken by the resident as an unsupervised medication.

The Service Plan, dated 6/26/24, indicated that the resident had a clear understanding of medications, purpose, dose and indication for her prescriptions. The resident was independent and could self-administer her medications unsupervised by nursing staff.

A nurse's note, dated 2/18/25 at 9:20 a.m., indicated the nursing staff responded to a call for assistance from a Certified Nurse Aide (CNA). At 8:43 a.m., resident was in bed, without breathing apparent, and was unresponsive to verbal or physical stimuli. No pulse was found, the resident was cold to the touch, and cardiopulmonary resuscitation (CPR) was started at 8:45 a.m. Emergency Medical Services (EMS) arrived at the facility at 8:52 a.m. and took charge in the resuscitation efforts. At 8:54 a.m., the resident was declared deceased by EMS and the family was notified.

Resident B's record was

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

reviewed on 3/18/25. The record documentation indicated the following:

- A nurse's note, dated 2/18/25 at 10:25 a.m., indicated the family was currently at the resident's bedside and staff were awaiting instructions for funeral arrangements.

- An administration noted, dated 2/23/25 at 9:05 a.m., indicated the resident was on a leave of absence. The resident was deceased on 2/18/25.

- An administration noted, dated 2/27/25 at 2:42 p.m., indicated the resident was on a leave of absence. The resident was deceased on 2/18/25.

- An administration noted, dated 2/28/25 at 9:36 a.m., indicated the resident was on a leave of absence. The resident was deceased on 2/18/25.

- An administration note, dated 3/1/2025 on 9:46 a.m., indicated the resident was monitored due to antidepressant medication. The nursing staff were to monitor for sedation, drowsiness, dry mouth, blurred vision, urinary retention, tachycardia, muscle tremors, agitation, headache, skin rash, photosensitivity (skin) excess weight gain. The staff were to document: the letter 'Y' if the resident was monitored and none of the above signs or

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

FORM APPROVED

OMB NO. 0938-0391

symptoms were observed. The letter 'N' was documented if the resident was monitored and any of the above was signs and symptoms were observed. The staff would then document accurately in the 'Other/ See Nurses Notes' findings. This was ordered to be completed two times a day for anti-depressant monitoring. This administrative note lacked the explanation of why the letter 'N' was documented. The resident was deceased on 2/18/25.

- An Administration note, dated 3/2/2025 on 9: 57 a.m., indicated the resident was being monitored for anticoagulant medication (blood thinning medication). The nursing staff were to monitor the resident for discolored urine, black tarry stools, sudden severe headache, nausea & vomiting, diarrhea, muscle joint pain, lethargy, bruising, sudden changes in mental status and/ or v/s, sob, nose bleeds. The staff were to document: the letter 'Y' if the resident was monitored and none of the above signs or symptoms were observed. The letter 'N' was documented if the resident were monitored and any of the above was signs and symptoms were observed. The staff would then document accurately in the 'Other/ See Nurses Notes' findings. This was ordered to be completed two times a day for

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

anticoagulation therapy monitoring. This administrative note lacked the explanation of why the letter 'N' was documented. The resident was deceased on 2/18/25.

- An Administration note, dated 3/3/2025 at 10:52 a.m., indicated the resident was deceased. The resident expired on 2/18/25.

- An Administration note, dated 3/3/2025 at 11:36 p.m., indicated the resident was on leave. The resident expired on 2/18/25

- An Administration note, dated 3/2/2025 at 1:40 p.m., indicated that an order was renewed for a full set of vitals and weight obtained, starting on the second day of each month. The resident was deceased on 2/18/25.

On 3/18/25, no policies on documentation were presented.

This Citation relates to Complaint IN00454400.

2. The Communication note with the family, dated 1/10/25 at 12:15 p.m., indicated staff notified the family member of Resident G's death. The family member wished to contact the rest of the family. The funeral home was contacted per the resident's wishes. The funeral home arrived to transport the resident's body. The coroner's

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

office was contacted, and they indicated they did not need to be notified but would assist the family as needed.

Resident G's record was reviewed on 3/18/25. The record documentation indicated the following:

- The Administration note, dated 1/10/25 at 5:03 p.m., indicated the resident's Wellness Assessment for Medicaid was completed every day shift. The resident passed away.

- The Administration note, dated 1/13/25 at 2:27 p.m., indicated the resident's Wellness Assessment for Medicaid was completed every day shift. The resident passed away.

- The Administration note, dated 1/14/25 at 4:51 p.m., indicated the resident's 4-hour safety check was conducted. The resident was deceased.

- The Administration note, dated 1/14/25 at 9:13 p.m., indicated the resident's 4-hour safety check was conducted. The resident passed away 1/10/25.

- The Administration note, dated 1/15/25 at 3: p.m., indicated the resident's Wellness Assessment for Medicaid was completed every day shift. The resident passed away.

- The Administration note, dated

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

1/17/25 at 4:53 p.m., indicated the resident was hospitalized.

- The Administration note, dated 1/17/25 at 11:39 p.m., indicated the resident's 4-hour safety check was conducted. The resident was deceased.

- The Administration note, dated 1/18/25 at 3:00 a.m., indicated the resident's 4-hour safety check was conducted.

- The Administration note, dated 1/18/25 at 12:15 p.m., indicated the resident's Wellness Assessment for Medicaid was completed every day shift. The resident passed away.

- The Administration note, dated 1/22/25 at 11:25 p.m., indicated the resident's 4-hour safety check was conducted.

- The Administration note, dated 1/23/25 at 3:02 a.m., indicated the resident's 4-hour safety check was conducted.

- The Administration note, dated 1/23/25 at 10:44 a.m., indicated the resident's Wellness Assessment for Medicaid was completed every day shift. The resident passed away.

- The Administration note, dated 1/24/25 at 1:50 a.m., indicated the resident's 4-hour safety check was conducted. The resident was expired.

- The Administration note, dated 1/24/25 at 1:46 p.m., indicated the resident's Wellness Assessment for Medicaid was completed every day shift. The resident passed away.

- The Administration note, dated 1/25/25 at 3:32 p.m., indicated the resident's Wellness Assessment for Medicaid was completed every day shift. The resident was deceased.

- The Administration note, dated 1/26/25 at 1:16 a.m., indicated the resident's 4-hour safety check was conducted.

- The Administration note, dated 1/26/25 at 1:41 p.m., indicated the resident's Wellness Assessment for Medicaid was completed every day shift. The resident was deceased.

- The Administration note, dated 1/27/25 at 10:46 a.m., indicated the resident's Wellness Assessment for Medicaid was completed every day shift. The resident was passed.

- The Administration note, dated 1/28/25 at 1:43 p.m., indicated the resident's Wellness Assessment for Medicaid was completed every day shift. The resident was expired.

3. The nurse's note, dated 2/5/25 at 12:35 p.m., indicated the nurse was alerted by a Qualified Medication Aide

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

(QMA) that Resident J had no pulse or breathing. The nurse went to the resident's room with a second nurse, and two nurses verified that the resident had no heartbeat or respirations. The time of death was 2/5/25 at 8:25 a.m. Family was at bedside. A call was placed to hospice, the Nurse Practitioner (NP), DON, and Assistant Director of Nursing (ADON). The resident's remains were picked up by the funeral home at 10:55 a.m.

Resident J's record was reviewed on 3/18/25. The record documentation indicated the following:

- The Administration note, dated 2/5/25 at 8:15 p.m., indicated that if the resident has to be sent to the hospital for any reason per the Power of Attorney (POA); she was only to go to two local hospitals, two times a day for the medical decision.

- The Administration note, dated 2/8/25 at 9:30 p.m., indicated the resident was on leave.

- The Administration note, dated 2/18/25 at 10:07 a.m., indicated if the resident had to be sent to the hospital for any reason per POA; she was only to go to two local hospitals, two times a day for medical decision.

- The Administration note, dated 2/19/25 at 8:11 a.m., indicated

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

the resident was LOA.

- The Administration note, dated 2/19/25 at 8:19 p.m., indicated the resident was on leave.

- The Administration note, dated 2/21/25 at 9:45 p.m., indicated the resident was on leave.

- The Administration note, dated 2/22/25 at 9:58 a.m., indicated if the resident had to be sent to the hospital for any reason per POA; she was only to go to two local hospitals, two times a day for medical decision. The resident was deceased.

- The Administration note, dated 2/22/25 9:01 p.m., indicated the resident was on leave.

- The Administration note, dated 2/23/25 at 9:32 p.m., indicated the resident was on leave.

- The Administration note, dated 2/26/25 at 8:14 a.m., indicated the resident was LOA.

- The Administration note, dated 2/26/25 at 4:22 p.m., indicated the resident was absent.

- The Administration note, dated 2/28/25 at 8:45 p.m., indicated the resident was on leave.

- The Administration note, dated 3/1/25 at 8:58 a.m., indicated the resident was LOA.

- The Administration note, dated

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

3/2/25 at 9:10 a.m., indicated the resident was LOA.

- The Administration note, dated 3/3/25 at 9:59 a.m., indicated if resident has to be sent to the hospital for any reason per POA; she was only to go to two local hospitals, two times a day for medical decision.

- The Administration note, dated 3/3/25 at 10:17 p.m., indicated the resident was on leave.

- The Administration note, dated 3/4/25 at 4:29 p.m., indicated the resident was absent from home with or without medications (AW).

- The Administration note, dated 3/5/25 at 8:58 a.m., indicated the resident was LOA.

- The Administration note, dated 3/5/25 at 10:23 p.m., indicated the resident was on leave.

- The Administration note, dated 3/7/25 at 9:02 a.m., indicated the resident was LOA.

During an e-mail sent on 3/18/25 at 1:43 p.m., the Regional Compliance Officer, failed to respond to the e-mail regarding information concerning documentation and billing.

During an interview, on 3/18/25 at 2:27 p.m., the DON indicated the IHCC documentation could

not be taken out of the system for Medicaid. The corporate office would not let them remove the documentation from the notes.

An e-mail was sent, on 3/18/25 at 1:43 p.m., to the Regional Compliance Officer related to documentation and billing. Regional Compliance Officer 51 failed to respond to the enquirer.

Based on record review and interview, the facility failed to ensure accurate documentation for 4 of 9 deceased or discharged residents.
(Residents H, G, J, B)

Findings Include:

1. The nurse's note, dated 3/5/25 at 8:50 a.m., indicated Resident H was observed not to be in the dining room for breakfast. A wellness check was initiated. Upon arriving at the resident's room, he was found on the bathroom floor, face down, unconscious, no pulse present, stiff blue extremities, and he was cold to touch. The nurse called the Assistant Director of Nursing (ADON) for assistance. No extraordinary measures were taken due to residents' DO NOT Resuscitate (DNR) code status. A call was made to emergency services system (EMS) and EMS pronounced the time of death at

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

8:50 am. The DON (Director of Nursing) contacted the family and the funeral home services.

Resident H's record was reviewed on 3/18/25. The record documentation indicated the following:

- The health status note, dated 3/5/25 at 10:27 a.m., indicated staff met with therapy to discuss the resident's participation and progress yesterday. The resident completed 60 minutes of Occupational Therapy (OT) without issue. Will continue to follow progress.

- The Administration note, dated 3/6/25 at 7:44 a.m., indicated the resident was AW (away without medications).

- The Administration note, dated 3/6/25 at 3:15 p.m., indicated the resident was AW

- The Administration note, dated 3/8/25 at 11:26 a.m., indicated for Resident H a Wellness Assessment for Medicaid was completed everyday shift.

- The Administration note, dated 3/9/25 at 9:02 p.m., indicated the resident was loa (leave of absence).

During an interview, on 3/18/25 at 1:30 p.m., a phone call was made to the Administrative Billing in the cooperate office to inquire about their policy

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

regarding documentation and billing after a death or discharge. The facility office manager indicated the number and name of who to contact for the administrative billing corporate office. During the multiple attempts to contact the corporate office, Corporate Staff Member 50, indicated she was unwilling to talk.

4. The record for Resident B was reviewed on 3/18/25 at 11:00 a.m. The resident's diagnoses included, but were not limited to, diabetes mellitus with diabetic chronic kidney disease, hemiplegia and hemiparesis following cerebral infarction affecting the resident's non-dominant side, polyneuropathy, chronic pain syndrome and occlusion and stenosis of bilateral carotid arteries.

The medication administration record (MAR) documentation indicated the resident self-medicated during the time frame of 2/18/25 to 3/18/25. The resident expired on 2/18/25.

During an interview, on 3/18/25 at 12:50 p.m., the resident's family member and POA indicated that the resident did expire on 2/18/25 and could not have taken her medications unsupervised through the month of February and March.

A physician's order, dated 6/18/24, indicated the staff were to provide the resident assistance with self-administration of oral and special medications.

A physician's order, dated 6/19/24, indicated that the resident was to have Aspirin 325mg (Milligram) by mouth one time a day related to her diagnosis of the occlusion and stenosis of her bilateral carotid arteries. The medication could be taken by the resident as an unsupervised medication.

The Service Plan, dated 6/26/24, indicated that the resident had a clear understanding of medications, purpose, dose and indication for her prescriptions. The resident was independent and could self-administer her medications unsupervised by nursing staff.

A nurse's note, dated 2/18/25 at 9:20 a.m., indicated the nursing staff responded to a call for assistance from a Certified Nurse Aide (CNA). At 8:43 a.m., resident was in bed, without breathing apparent, and was unresponsive to verbal or physical stimuli. No pulse was found, the resident was cold to the touch, and cardiopulmonary resuscitation (CPR) was started at 8:45 a.m. Emergency Medical Services (EMS) arrived at the facility at 8:52 a.m. and took

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

charge in the resuscitation efforts. At 8:54 a.m., the resident was declared deceased by EMS and the family was notified.

Resident B's record was reviewed on 3/18/25. The record documentation indicated the following:

- A nurse's note, dated 2/18/25 at 10:25 a.m., indicated the family was currently at the resident's bedside and staff were awaiting instructions for funeral arrangements.

- An administration noted, dated 2/23/25 at 9:05 a.m., indicated the resident was on a leave of absence. The resident was deceased on 2/18/25.

- An administration noted, dated 2/27/25 at 2:42 p.m., indicated the resident was on a leave of absence. The resident was deceased on 2/18/25.

- An administration noted, dated 2/28/25 at 9:36 a.m., indicated the resident was on a leave of absence. The resident was deceased on 2/18/25.

- An administration note, dated 3/1/2025 on 9:46 a.m., indicated the resident was monitored due to antidepressant medication. The nursing staff were to monitor for sedation, drowsiness, dry mouth, blurred vision, urinary retention,

tachycardia, muscle tremors, agitation, headache, skin rash, photosensitivity (skin) excess weight gain. The staff were to document: the letter 'Y' if the resident was monitored and none of the above signs or symptoms were observed. The letter 'N' was documented if the resident was monitored and any of the above was signs and symptoms were observed. The staff would then document accurately in the 'Other/ See Nurses Notes' findings. This was ordered to be completed two times a day for anti-depressant monitoring. This administrative note lacked the explanation of why the letter 'N' was documented. The resident was deceased on 2/18/25.

- An Administration note, dated 3/2/2025 on 9: 57 a.m., indicated the resident was being monitored for anticoagulant medication (blood thinning medication). The nursing staff were to monitor the resident for discolored urine, black tarry stools, sudden severe headache, nausea & vomiting, diarrhea, muscle joint pain, lethargy, bruising, sudden changes in mental status and/ or v/s, sob, nose bleeds. The staff were to document: the letter 'Y' if the resident was monitored and none of the above signs or symptoms were observed. The letter 'N' was documented if the resident were

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

FORM APPROVED

OMB NO. 0938-0391

monitored and any of the above was signs and symptoms were observed. The staff would then document accurately in the 'Other/ See Nurses Notes' findings. This was ordered to be completed two times a day for anticoagulation therapy monitoring. This administrative note lacked the explanation of why the letter 'N' was documented. The resident was deceased on 2/18/25.

- An Administration note, dated 3/3/2025 at 10:52 a.m., indicated the resident was deceased. The resident expired on 2/18/25.

- An Administration note, dated 3/3/2025 at 11:36 p.m., indicated the resident was on leave. The resident expired on 2/18/25

- An Administration note, dated 3/2/2025 at 1:40 p.m., indicated that an order was renewed for a full set of vitals and weight obtained, starting on the second day of each month. The resident was deceased on 2/18/25.

On 3/18/25, no policies on documentation were presented.

This Citation relates to Complaint IN00454400.

2. The Communication note with the family, dated 1/10/25 at 12:15 p.m., indicated staff notified the family member of

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

Resident G's death. The family member wished to contact the rest of the family. The funeral home was contacted per the resident's wishes. The funeral home arrived to transport the resident's body. The coroner's office was contacted, and they indicated they did not need to be notified but would assist the family as needed.

Resident G's record was reviewed on 3/18/25. The record documentation indicated the following:

- The Administration note, dated 1/10/25 at 5:03 p.m., indicated the resident's Wellness Assessment for Medicaid was completed every day shift. The resident passed away.

- The Administration note, dated 1/13/25 at 2:27 p.m., indicated the resident's Wellness Assessment for Medicaid was completed every day shift. The resident passed away.

- The Administration note, dated 1/14/25 at 4:51 p.m., indicated the resident's 4-hour safety check was conducted. The resident was deceased.

- The Administration note, dated 1/14/25 at 9:13 p.m., indicated the resident's 4-hour safety check was conducted. The resident passed away 1/10/25.

- The Administration note, dated

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

1/15/25 at 3: p.m., indicated the resident's Wellness Assessment for Medicaid was completed every day shift. The resident passed away.

- The Administration note, dated 1/17/25 at 4:53 p.m., indicated the resident was hospitalized.

- The Administration note, dated 1/17/25 at 11:39 p.m., indicated the resident's 4-hour safety check was conducted. The resident was deceased.

- The Administration note, dated 1/18/25 at 3:00 a.m., indicated the resident's 4-hour safety check was conducted.

- The Administration note, dated 1/18/25 at 12:15 p.m., indicated the resident's Wellness Assessment for Medicaid was completed every day shift. The resident passed away.

- The Administration note, dated 1/22/25 at 11:25 p.m., indicated the resident's 4-hour safety check was conducted.

- The Administration note, dated 1/23/25 at 3:02 a.m., indicated the resident's 4-hour safety check was conducted.

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

- The Administration note, dated 1/23/25 at 10:44 a.m., indicated the resident's Wellness Assessment for Medicaid was completed every day shift. The resident passed away.

- The Administration note, dated 1/24/25 at 1:50 a.m., indicated the resident's 4-hour safety check was conducted. The resident was expired.

- The Administration note, dated 1/24/25 at 1:46 p.m., indicated the resident's Wellness Assessment for Medicaid was completed every day shift. The resident passed away.

- The Administration note, dated 1/25/25 at 3:32 p.m., indicated the resident's Wellness Assessment for Medicaid was completed every day shift. The resident was deceased.

- The Administration note, dated 1/26/25 at 1:16 a.m., indicated the resident's 4-hour safety check was conducted.

- The Administration note, dated 1/26/25 at 1:41 p.m., indicated the resident's Wellness Assessment for Medicaid was completed every day shift. The resident was deceased.

- The Administration note, dated 1/27/25 at 10:46 a.m., indicated the resident's Wellness Assessment for Medicaid was completed every day shift. The

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

resident was passed.

- The Administration note, dated 1/28/25 at 1:43 p.m., indicated the resident's Wellness Assessment for Medicaid was completed every day shift. The resident was expired.

3. The nurse's note, dated 2/5/25 at 12:35 p.m., indicated the nurse was alerted by a Qualified Medication Aide (QMA) that Resident J had no pulse or breathing. The nurse went to the resident's room with a second nurse, and two nurses verified that the resident had no heartbeat or respirations. The time of death was 2/5/25 at 8:25 a.m. Family was at bedside. A call was placed to hospice, the Nurse Practitioner (NP), DON, and Assistant Director of Nursing (ADON). The resident's remains were picked up by the funeral home at 10:55 a.m.

Resident J's record was reviewed on 3/18/25. The record documentation indicated the following:

- The Administration note, dated 2/5/25 at 8:15 p.m., indicated that if the resident has to be sent to the hospital for any reason per the Power of Attorney (POA); she was only to go to two local hospitals, two times a day for the medical decision.

- The Administration note, dated

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

2/8/25 at 9:30 p.m., indicated the resident was on leave.

- The Administration note, dated 2/18/25 at 10:07 a.m., indicated if the resident had to be sent to the hospital for any reason per POA; she was only to go to two local hospitals, two times a day for medical decision.
- The Administration note, dated 2/19/25 at 8:11 a.m., indicated the resident was LOA.
- The Administration note, dated 2/19/25 at 8:19 p.m., indicated the resident was on leave.
- The Administration note, dated 2/21/25 at 9:45 p.m., indicated the resident was on leave.
- The Administration note, dated 2/22/25 at 9:58 a.m., indicated if the resident had to be sent to the hospital for any reason per POA; she was only to go to two local hospitals, two times a day for medical decision. The resident was deceased.
- The Administration note, dated 2/22/25 9:01 p.m., indicated the resident was on leave.
- The Administration note, dated 2/23/25 at 9:32 p.m., indicated the resident was on leave.
- The Administration note, dated 2/26/25 at 8:14 a.m., indicated the resident was LOA.

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

- The Administration note, dated 2/26/25 at 4:22 p.m., indicated the resident was absent.
- The Administration note, dated 2/28/25 at 8:45 p.m., indicated the resident was on leave.
- The Administration note, dated 3/1/25 at 8:58 a.m., indicated the resident was LOA.
- The Administration note, dated 3/2/25 at 9:10 a.m., indicated the resident was LOA.
- The Administration note, dated 3/3/25 at 9:59 a.m., indicated if resident has to be sent to the hospital for any reason per POA; she was only to go to two local hospitals, two times a day for medical decision.
- The Administration note, dated 3/3/25 at 10:17 p.m., indicated the resident was on leave.
- The Administration note, dated 3/4/25 at 4:29 p.m., indicated the resident was absent from home with or without medications (AW).
- The Administration note, dated 3/5/25 at 8:58 a.m., indicated the resident was LOA.
- The Administration note, dated 3/5/25 at 10:23 p.m., indicated the resident was on leave.
- The Administration note, dated 3/7/25 at 9:02 a.m., indicated

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

the resident was LOA.

During an e-mail sent on 3/18/25 at 1:43 p.m., the Regional Compliance Officer, failed to respond to the e-mail regarding information concerning documentation and billing.

During an interview, on 3/18/25 at 2:27 p.m., the DON indicated the IHCC documentation could not be taken out of the system for Medicaid. The corporate office would not let them remove the documentation from the notes.

An e-mail was sent, on 3/18/25 at 1:43 p.m., to the Regional Compliance Officer related to documentation and billing. Regional Compliance Officer 51 failed to respond to the enquirer.

Based on record review and interview, the facility failed to ensure accurate documentation for 4 of 9 deceased or discharged residents.
(Residents H, G, J, B)

Findings Include:

1. The nurse's note, dated 3/5/25 at 8:50 a.m., indicated Resident H was observed not to be in the dining room for breakfast. A wellness check was initiated. Upon arriving at the resident's room, he was found on the bathroom floor, face

down, unconscious, no pulse present, stiff blue extremities, and he was cold to touch. The nurse called the Assistant Director of Nursing (ADON) for assistance. No extraordinary measures were taken due to residents' DO NOT Resuscitate (DNR) code status. A call was made to emergency services system (EMS) and EMS pronounced the time of death at 8:50 am. The DON (Director of Nursing) contacted the family and the funeral home services.

Resident H's record was reviewed on 3/18/25. The record documentation indicated the following:

- The health status note, dated 3/5/25 at 10:27 a.m., indicated staff met with therapy to discuss the resident's participation and progress yesterday. The resident completed 60 minutes of Occupational Therapy (OT) without issue. Will continue to follow progress.

- The Administration note, dated 3/6/25 at 7:44 a.m., indicated the resident was AW (away without medications).

- The Administration note, dated 3/6/25 at 3:15 p.m., indicated the resident was AW

- The Administration note, dated 3/8/25 at 11:26 a.m., indicated for Resident H a Wellness Assessment for Medicaid was

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

FORM APPROVED

OMB NO. 0938-0391

completed everyday shift.

- The Administration note, dated 3/9/25 at 9:02 p.m., indicated the resident was loa (leave of absence).

During an interview, on 3/18/25 at 1:30 p.m., a phone call was made to the Administrative Billing in the cooperate office to inquire about their policy regarding documentation and billing after a death or discharge. The facility office manager indicated the number and name of who to contact for the administrative billing cooperate office. During the multiple attempts to contact the cooperate office, Corperate Staff Member 50, indicated she was unwilling to talk.

4. The record for Resident B was reviewed on 3/18/25 at 11:00 a.m. The resident's diagnoses included, but were not limited to, diabetes mellitus with diabetic chronic kidney disease, hemiplegia and hemiparesis following cerebral infarction affecting the resident's non-dominant side, polyneuropathy, chronic pain syndrome and occlusion and stenosis of bilateral carotid arteries.

The medication administration record (MAR) documentation indicated the resident self-medicated during the time

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

FORM APPROVED

OMB NO. 0938-0391

frame of 2/18/25 to 3/18/25. The resident expired on 2/18/25.

During an interview, on 3/18/25 at 12:50 p.m., the resident's family member and POA indicated that the resident did expire on 2/18/25 and could not have taken her medications unsupervised through the month of February and March.

A physician's order, dated 6/18/24, indicated the staff were to provide the resident assistance with self-administration of oral and special medications.

A physician's order, dated 6/19/24, indicated that the resident was to have Aspirin 325mg (Milligram) by mouth one time a day related to her diagnosis of the occlusion and stenosis of her bilateral carotid arteries. The medication could be taken by the resident as an unsupervised medication.

The Service Plan, dated 6/26/24, indicated that the resident had a clear understanding of medications, purpose, dose and indication for her prescriptions. The resident was independent and could self-administer her medications unsupervised by nursing staff.

A nurse's note, dated 2/18/25 at 9:20 a.m., indicated the nursing staff responded to a call for assistance from a Certified

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

Nurse Aide (CNA). At 8:43 a.m., resident was in bed, without breathing apparent, and was unresponsive to verbal or physical stimuli. No pulse was found, the resident was cold to the touch, and cardiopulmonary resuscitation (CPR) was started at 8:45 a.m. Emergency Medical Services (EMS) arrived at the facility at 8:52 a.m. and took charge in the resuscitation efforts. At 8:54 a.m., the resident was declared deceased by EMS and the family was notified.

Resident B's record was reviewed on 3/18/25. The record documentation indicated the following:

- A nurse's note, dated 2/18/25 at 10:25 a.m., indicated the family was currently at the resident's bedside and staff were awaiting instructions for funeral arrangements.

- An administration noted, dated 2/23/25 at 9:05 a.m., indicated the resident was on a leave of absence. The resident was deceased on 2/18/25.

- An administration noted, dated 2/27/25 at 2:42 p.m., indicated the resident was on a leave of absence. The resident was deceased on 2/18/25.

- An administration noted, dated 2/28/25 at 9:36 a.m., indicated the resident was on a leave of

absence. The resident was deceased on 2/18/25.

- An administration note, dated 3/1/2025 on 9:46 a.m., indicated the resident was monitored due to antidepressant medication. The nursing staff were to monitor for sedation, drowsiness, dry mouth, blurred vision, urinary retention, tachycardia, muscle tremors, agitation, headache, skin rash, photosensitivity (skin) excess weight gain. The staff were to document: the letter 'Y' if the resident was monitored and none of the above signs or symptoms were observed. The letter 'N' was documented if the resident was monitored and any of the above was signs and symptoms were observed. The staff would then document accurately in the 'Other/ See Nurses Notes' findings. This was ordered to be completed two times a day for anti-depressant monitoring. This administrative note lacked the explanation of why the letter 'N' was documented. The resident was deceased on 2/18/25.

- An Administration note, dated 3/2/2025 on 9: 57 a.m., indicated the resident was being monitored for anticoagulant medication (blood thinning medication). The nursing staff were to monitor the resident for discolored urine, black tarry stools, sudden severe

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

headache, nausea & vomiting, diarrhea, muscle joint pain, lethargy, bruising, sudden changes in mental status and/ or v/s, sob, nose bleeds. The staff were to document: the letter 'Y' if the resident was monitored and none of the above signs or symptoms were observed. The letter 'N' was documented if the resident were monitored and any of the above was signs and symptoms were observed. The staff would then document accurately in the 'Other/ See Nurses Notes' findings. This was ordered to be completed two times a day for anticoagulation therapy monitoring. This administrative note lacked the explanation of why the letter 'N' was documented. The resident was deceased on 2/18/25.

- An Administration note, dated 3/3/2025 at 10:52 a.m., indicated the resident was deceased. The resident expired on 2/18/25.

- An Administration note, dated 3/3/2025 at 11:36 p.m., indicated the resident was on leave. The resident expired on 2/18/25

- An Administration note, dated 3/2/2025 at 1:40 p.m., indicated that an order was renewed for a full set of vitals and weight obtained, starting on the second day of each month. The resident

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

was deceased on 2/18/25.

On 3/18/25, no policies on documentation were presented.

This Citation relates to Complaint IN00454400.

2. The Communication note with the family, dated 1/10/25 at 12:15 p.m., indicated staff notified the family member of Resident G's death. The family member wished to contact the rest of the family. The funeral home was contacted per the resident's wishes. The funeral home arrived to transport the resident's body. The coroner's office was contacted, and they indicated they did not need to be notified but would assist the family as needed.

Resident G's record was reviewed on 3/18/25. The record documentation indicated the following:

- The Administration note, dated 1/10/25 at 5:03 p.m., indicated the resident's Wellness Assessment for Medicaid was completed every day shift. The resident passed away.

- The Administration note, dated 1/13/25 at 2:27 p.m., indicated the resident's Wellness Assessment for Medicaid was completed every day shift. The resident passed away.

- The Administration note, dated

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

1/14/25 at 4:51 p.m., indicated the resident's 4-hour safety check was conducted. The resident was deceased.

- The Administration note, dated 1/14/25 at 9:13 p.m., indicated the resident's 4-hour safety check was conducted. The resident passed away 1/10/25.

- The Administration note, dated 1/15/25 at 3: p.m., indicated the resident's Wellness Assessment for Medicaid was completed every day shift. The resident passed away.

- The Administration note, dated 1/17/25 at 4:53 p.m., indicated the resident was hospitalized.

- The Administration note, dated 1/17/25 at 11:39 p.m., indicated the resident's 4-hour safety check was conducted. The resident was deceased.

- The Administration note, dated 1/18/25 at 3:00 a.m., indicated the resident's 4-hour safety check was conducted.

- The Administration note, dated 1/18/25 at 12:15 p.m., indicated the resident's Wellness Assessment for Medicaid was completed every day shift. The resident passed away.

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

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|---|--|--|--|
| <ul style="list-style-type: none">- The Administration note, dated 1/22/25 at 11:25 p.m., indicated the resident's 4-hour safety check was conducted.- The Administration note, dated 1/23/25 at 3:02 a.m., indicated the resident's 4-hour safety check was conducted.- The Administration note, dated 1/23/25 at 10:44 a.m., indicated the resident's Wellness Assessment for Medicaid was completed every day shift. The resident passed away.- The Administration note, dated 1/24/25 at 1:50 a.m., indicated the resident's 4-hour safety check was conducted. The resident was expired.- The Administration note, dated 1/24/25 at 1:46 p.m., indicated the resident's Wellness Assessment for Medicaid was completed every day shift. The resident passed away.- The Administration note, dated 1/25/25 at 3:32 p.m., indicated the resident's Wellness Assessment for Medicaid was completed every day shift. The resident was deceased.- The Administration note, dated 1/26/25 at 1:16 a.m., indicated the resident's 4-hour safety check was conducted.- The Administration note, dated 1/26/25 at 1:41 p.m., indicated | | | |
|---|--|--|--|

the resident's Wellness Assessment for Medicaid was completed every day shift. The resident was deceased.

- The Administration note, dated 1/27/25 at 10:46 a.m., indicated the resident's Wellness Assessment for Medicaid was completed every day shift. The resident was passed.

- The Administration note, dated 1/28/25 at 1:43 p.m., indicated the resident's Wellness Assessment for Medicaid was completed every day shift. The resident was expired.

3. The nurse's note, dated 2/5/25 at 12:35 p.m., indicated the nurse was alerted by a Qualified Medication Aide (QMA) that Resident J had no pulse or breathing. The nurse went to the resident's room with a second nurse, and two nurses verified that the resident had no heartbeat or respirations. The time of death was 2/5/25 at 8:25 a.m. Family was at bedside. A call was placed to hospice, the Nurse Practitioner (NP), DON, and Assistant Director of Nursing (ADON). The resident's remains were picked up by the funeral home at 10:55 a.m.

Resident J's record was reviewed on 3/18/25. The record documentation indicated the following:

- The Administration note, dated

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

2/5/25 at 8:15 p.m., indicated that if the resident has to be sent to the hospital for any reason per the Power of Attorney (POA); she was only to go to two local hospitals, two times a day for the medical decision.

- The Administration note, dated 2/8/25 at 9:30 p.m., indicated the resident was on leave.

- The Administration note, dated 2/18/25 at 10:07 a.m., indicated if the resident had to be sent to the hospital for any reason per POA; she was only to go to two local hospitals, two times a day for medical decision.

- The Administration note, dated 2/19/25 at 8:11 a.m., indicated the resident was LOA.

- The Administration note, dated 2/19/25 at 8:19 p.m., indicated the resident was on leave.

- The Administration note, dated 2/21/25 at 9:45 p.m., indicated the resident was on leave.

- The Administration note, dated 2/22/25 at 9:58 a.m., indicated if the resident had to be sent to the hospital for any reason per POA; she was only to go to two local hospitals, two times a day for medical decision. The resident was deceased.

- The Administration note, dated 2/22/25 9:01 p.m., indicated the

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

resident was on leave.

- The Administration note, dated 2/23/25 at 9:32 p.m., indicated the resident was on leave.

- The Administration note, dated 2/26/25 at 8:14 a.m., indicated the resident was LOA.

- The Administration note, dated 2/26/25 at 4:22 p.m., indicated the resident was absent.

- The Administration note, dated 2/28/25 at 8:45 p.m., indicated the resident was on leave.

- The Administration note, dated 3/1/25 at 8:58 a.m., indicated the resident was LOA.

- The Administration note, dated 3/2/25 at 9:10 a.m., indicated the resident was LOA.

- The Administration note, dated 3/3/25 at 9:59 a.m., indicated if resident has to be sent to the hospital for any reason per POA; she was only to go to two local hospitals, two times a day for medical decision.

- The Administration note, dated 3/3/25 at 10:17 p.m., indicated the resident was on leave.

- The Administration note, dated 3/4/25 at 4:29 p.m., indicated the resident was absent from home with or without medications (AW).

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

- The Administration note, dated 3/5/25 at 8:58 a.m., indicated the resident was LOA.

- The Administration note, dated 3/5/25 at 10:23 p.m., indicated the resident was on leave.

- The Administration note, dated 3/7/25 at 9:02 a.m., indicated the resident was LOA.

During an e-mail sent on 3/18/25 at 1:43 p.m., the Regional Compliance Officer, failed to respond to the e-mail regarding information concerning documentation and billing.

During an interview, on 3/18/25 at 2:27 p.m., the DON indicated the IHCC documentation could not be taken out of the system for Medicaid. The corporate office would not let them remove the documentation from the notes.

An e-mail was sent, on 3/18/25 at 1:43 p.m., to the Regional Compliance Officer related to documentation and billing. Regional Compliance Officer 51 failed to respond to the enquirer.

Based on record review and interview, the facility failed to ensure accurate documentation for 4 of 9 deceased or discharged residents.
(Residents H, G, J, B)

Findings Include:

1. The nurse's note, dated 3/5/25 at 8:50 a.m., indicated Resident H was observed not to be in the dining room for breakfast. A wellness check was initiated. Upon arriving at the resident's room, he was found on the bathroom floor, face down, unconscious, no pulse present, stiff blue extremities, and he was cold to touch. The nurse called the Assistant Director of Nursing (ADON) for assistance. No extraordinary measures were taken due to residents' DO NOT Resuscitate (DNR) code status. A call was made to emergency services system (EMS) and EMS pronounced the time of death at 8:50 am. The DON (Director of Nursing) contacted the family and the funeral home services.

Resident H's record was reviewed on 3/18/25. The record documentation indicated the following:

- The health status note, dated 3/5/25 at 10:27 a.m., indicated staff met with therapy to discuss the resident's participation and progress yesterday. The resident completed 60 minutes of Occupational Therapy (OT) without issue. Will continue to follow progress.

- The Administration note, dated 3/6/25 at 7:44 a.m., indicated

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

the resident was AW (away without medications).

- The Administration note, dated 3/6/25 at 3:15 p.m., indicated the resident was AW

- The Administration note, dated 3/8/25 at 11:26 a.m., indicated for Resident H a Wellness Assessment for Medicaid was completed everyday shift.

- The Administration note, dated 3/9/25 at 9:02 p.m., indicated the resident was loa (leave of absence).

During an interview, on 3/18/25 at 1:30 p.m., a phone call was made to the Administrative Billing in the cooperate office to inquire about their policy regarding documentation and billing after a death or discharge. The facility office manager indicated the number and name of who to contact for the administrative billing cooperate office. During the multiple attempts to contact the cooperate office, Corperate Staff Member 50, indicated she was unwilling to talk.

4. The record for Resident B was reviewed on 3/18/25 at 11:00 a.m. The resident's diagnoses included, but were not limited to, diabetes mellitus with diabetic chronic kidney disease, hemiplegia and hemiparesis following cerebral infarction affecting the resident's

non-dominant side, polyneuropathy, chronic pain syndrome and occlusion and stenosis of bilateral carotid arteries.

The medication administration record (MAR) documentation indicated the resident self-medicated during the time frame of 2/18/25 to 3/18/25. The resident expired on 2/18/25.

During an interview, on 3/18/25 at 12:50 p.m., the resident's family member and POA indicated that the resident did expire on 2/18/25 and could not have taken her medications unsupervised through the month of February and March.

A physician's order, dated 6/18/24, indicated the staff were to provide the resident assistance with self-administration of oral and special medications.

A physician's order, dated 6/19/24, indicated that the resident was to have Aspirin 325mg (Milligram) by mouth one time a day related to her diagnosis of the occlusion and stenosis of her bilateral carotid arteries. The medication could be taken by the resident as an unsupervised medication.

The Service Plan, dated 6/26/24, indicated that the resident had a clear understanding of medications,

purpose, dose and indication for her prescriptions. The resident was independent and could self-administer her medications unsupervised by nursing staff.

A nurse's note, dated 2/18/25 at 9:20 a.m., indicated the nursing staff responded to a call for assistance from a Certified Nurse Aide (CNA). At 8:43 a.m., resident was in bed, without breathing apparent, and was unresponsive to verbal or physical stimuli. No pulse was found, the resident was cold to the touch, and cardiopulmonary resuscitation (CPR) was started at 8:45 a.m. Emergency Medical Services (EMS) arrived at the facility at 8:52 a.m. and took charge in the resuscitation efforts. At 8:54 a.m., the resident was declared deceased by EMS and the family was notified.

Resident B's record was reviewed on 3/18/25. The record documentation indicated the following:

- A nurse's note, dated 2/18/25 at 10:25 a.m., indicated the family was currently at the resident's bedside and staff were awaiting instructions for funeral arrangements.

- An administration noted, dated 2/23/25 at 9:05 a.m., indicated the resident was on a leave of absence. The resident was

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

deceased on 2/18/25.

- An administration noted, dated 2/27/25 at 2:42 p.m., indicated the resident was on a leave of absence. The resident was deceased on 2/18/25.

- An administration noted, dated 2/28/25 at 9:36 a.m., indicated the resident was on a leave of absence. The resident was deceased on 2/18/25.

- An administration note, dated 3/1/2025 on 9:46 a.m., indicated the resident was monitored due to antidepressant medication. The nursing staff were to monitor for sedation, drowsiness, dry mouth, blurred vision, urinary retention, tachycardia, muscle tremors, agitation, headache, skin rash, photosensitivity (skin) excess weight gain. The staff were to document: the letter 'Y' if the resident was monitored and none of the above signs or symptoms were observed. The letter 'N' was documented if the resident was monitored and any of the above was signs and symptoms were observed. The staff would then document accurately in the 'Other/ See Nurses Notes' findings. This was ordered to be completed two times a day for anti-depressant monitoring. This administrative note lacked the explanation of why the letter 'N' was documented. The resident

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

was deceased on 2/18/25.

- An Administration note, dated 3/2/2025 on 9: 57 a.m., indicated the resident was being monitored for anticoagulant medication (blood thinning medication). The nursing staff were to monitor the resident for discolored urine, black tarry stools, sudden severe headache, nausea & vomiting, diarrhea, muscle joint pain, lethargy, bruising, sudden changes in mental status and/ or v/s, sob, nose bleeds. The staff were to document: the letter 'Y' if the resident was monitored and none of the above signs or symptoms were observed. The letter 'N' was documented if the resident were monitored and any of the above was signs and symptoms were observed. The staff would then document accurately in the 'Other/ See Nurses Notes' findings. This was ordered to be completed two times a day for anticoagulation therapy monitoring. This administrative note lacked the explanation of why the letter 'N' was documented. The resident was deceased on 2/18/25.

- An Administration note, dated 3/3/2025 at 10:52 a.m., indicated the resident was deceased. The resident expired on 2/18/25.

- An Administration note, dated

DEPARTMENT OF HEALTH AND HUMAN SERVICES

FORM APPROVED

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OMB NO. 0938-0391

3/3/2025 at 11:36 p.m., indicated the resident was on leave. The resident expired on 2/18/25

- An Administration note, dated 3/2/2025 at 1:40 p.m., indicated that an order was renewed for a full set of vitals and weight obtained, starting on the second day of each month. The resident was deceased on 2/18/25.

On 3/18/25, no policies on documentation were presented.

This Citation relates to Complaint IN00454400.

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