STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTIONS	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
		A. BUILDING B. WING	07/23/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
VIVERA SENIOR LIVING OF JEFFERSONVILLE	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 was for the Investigation of Complaints IN00461331, IN00461473, IN00461563, IN00462828 and IN00463434. Complaint IN00461331 - State deficiencies related to the allegations are cited at R0243, R0272 and R0297. Complaint IN00461473 - State deficiencies related to the allegations is cited at R0272. Complaint IN00461563 - No deficiencies related to the allegations are cited. Complaint IN00462828 - State deficiencies related to the allegations are cited at R0272 and R0352. Complaint IN00463434 - State deficiencies related to the allegations are cited at R0243, R0272 and R0297. Survey dates: July 21, 22 and	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.	

	23, 2025 Facility number: 015121 Residential Census: 102 These State Residential Findings are cited in accordance with 410 IAC 16.2-5. Quality review completed on July 29, 2025.			
R 0243	Health Services - Deficiency 410 IAC 16.2-5-4(e)(3) (3) The individual administering the medication shall document the administration in the individual ' s medication and treatment records that indicate the: (A) time; (B) name of medication or treatment; (C) dosage (if applicable); and (D) name or initials of the person administering the drug or treatment.	R 0243	**1 What Corrective action(s) will be accomplished for those residents found to have been affected by the deficient practice ; no residents experienced adverse effects from the alleged deficient practice.** a **2 How the facility will identify other residents having the potential to be affected by the same deficient practice and what corrective will be taken** a All residents requiring proper documentation of medications,	08/15/2025

	Based on interview and record review, the facility failed to ensure the medication administration records accurately reflected the administration of narcotic medications for 3 of 4 residents reviewed for medication administration. (Residents B, H, and K) Findings include: 1. The clinical record for Resident B was reviewed on 7/22/25 at 11:31 a.m. The resident's diagnoses included, but were not limited to anxiety and porphyria. The June 2025 and July 2025 controlled drug use record indicated the resident received Morphine (narcotic pain medication) 30 mg (milligrams) on the following dates and times: - 6/03/04 at 9:00 p.m. - 6/04/25 at 9:00 p.m. - 6/05/25 at 9:00 a.m. - 6/08/25 at 9:00 a.m. - 6/16/25 at 9:00 a.m. - 6/19/25 at 9:00 a.m. - 6/21/25 at 9:00 a.m. - 6/22/25 at 9:00 a.m.		had the potential to be affected by the alleged deficient practice. DON or designee will provide an in-service to all QMAs and Nurses on properly documenting medication administration in real time in the EMR. Employees found to be out of compliance with properly documenting will receive additional education and possible corrective action. **3 What measures will be put into place or what systemic changes the facility will make to ensure that the deficient practice does not recur:** a An inservice will be held by the Director of Nursing for all QMAs and Nurses. Any clinical staff member out of compliance with facility's policies and protocols relating to documentation will receive progressive corrective action. The Director of Nursing, or designee will educate all newly hired clinical staff on policies and protocols	

	- 6/28/25 at 9:00 a.m. - 6/29/25 at 9:00 a.m. and 9:00 p.m. - 6/30/25 at 9:00 a.m. - 7/10/25 at 9:00 p.m. - 7/15/25 at 9:00 a.m. and 9:00 p.m. - 7/17/25 at 9:00 p.m. The June and July 2025 medication administration records lacked documentation of the administration of the medication. During an interview, on 7/23/25 at 2:11 p.m., Licensed Practical Nurse (LPN) 9 indicated when narcotics are administered, the medication should be signed out on the controlled drug record when removed and once administered, the medication administration record should be signed by the nurse. 2. The clinical record for Resident H was reviewed on 7/22/25 at 12:02 p.m. The resident's diagnosis included, but was not limited to, insomnia.		relating to proper documentation during employee job-specific orientation moving forward. **4 How the corrective action(s) will be monitored to ensure the deficient practice will not recur, i.e what quality assurance program will be put into place:** a The Director of Nursing or designee will audit documentation five (5) times per week for two (2) months, and as needed, then one (1) time a month for twelve (12) months, and then as needed to ensure that documentation is properly being entered into the EMR. Results to be reviewed at monthly QI meetings and make further recommendations based off audit results **5 By what date will the systematic changes be completed**	

	The physician's order, dated 12/24/24, indicated the resident was to receive Clonazepam (narcotic medication used for sleep disorders) 0.5 mg (milligrams) every evening at 9:00 p.m. The June 2025 controlled drug use record indicated the resident received the medication at 9:00 p.m. on 6/2/25, 6/5/25 and 6/16/25. The June 2025 medication administration record lacked documentation of the administration of the medication. 3. The clinical record for Resident K was reviewed on 7/22/25 at 1:45 p.m. The resident's diagnosis included, but was not limited to, chronic pain syndrome. The June and July 2025 medication administration record indicated the resident was to receive Oxycodone (narcotic pain medication) 10-325 mg every 4 hours at 12:00 a.m., 6:00 a.m., 12:00 p.m. and 6:00 p.m. The June and July 2025 controlled drug use record indicated the medication was administered on the following dates and times: - 6/07/25 at 12:00 a.m.		a Education and in-service will be provided to all clinical staff on or by 8/15/25	

	- 6/08/25 at 12:00 a.m. - 6/09/25 at 12:00 a.m. - 6/12/25 at 6:00 a.m. - 6/16/25 at 6:00 p.m. - 6/29/25 at 12:00 a.m. - 6/30/25 at 12:00 a.m. and 6:00 p.m. - 7/10/25 at 12:00 p.m. - 7/11/25 at 12:00 p.m. - 7/12/25 at 12:00 a.m. and 12:00 p.m. - 7/13/25 at 12:00 a.m. and 12:00 p.m. - 7/16/25 at 12:00 a.m. - 7/17/25 at 12:00 a.m. The June 2025 and July 2025 medication administration record lacked documentation of the administration of the medication. On 7/23/25 at 1:55 p.m., the Clinical Specialist provided a current copy of the document titled "Medication Management, Administration, & Storage" dated 3/2022. It included, but was not limited to, "Documentation...At the time of administration, the licensed nurse or QMA administering the medication will document the			

	administration in the medication...administration record that includes...Name or initials of the person administering the drug...." This citation relates to Complaints IN00461331 and IN00463434. Based on interview and record review, the facility failed to ensure the medication administration records accurately reflected the administration of narcotic medications for 3 of 4 residents reviewed for medication administration. (Residents B, H, and K) Findings include: 1. The clinical record for Resident B was reviewed on 7/22/25 at 11:31 a.m. The resident's diagnoses included, but were not limited to anxiety and porphyria. The June 2025 and July 2025 controlled drug use record indicated the resident received Morphine (narcotic pain medication) 30 mg (milligrams) on the following dates and times: - 6/03/04 at 9:00 p.m. - 6/04/25 at 9:00 p.m. - 6/05/25 at 9:00 a.m.			

	- 6/08/25 at 9:00 a.m. - 6/16/25 at 9:00 a.m. - 6/19/25 at 9:00 a.m. - 6/21/25 at 9:00 a.m. - 6/22/25 at 9:00 a.m. - 6/28/25 at 9:00 a.m. - 6/29/25 at 9:00 a.m. and 9:00 p.m. - 6/30/25 at 9:00 a.m. - 7/10/25 at 9:00 p.m. - 7/15/25 at 9:00 a.m. and 9:00 p.m. - 7/17/25 at 9:00 p.m. The June and July 2025 medication administration records lacked documentation of the administration of the medication. During an interview, on 7/23/25 at 2:11 p.m., Licensed Practical Nurse (LPN) 9 indicated when narcotics are administered, the medication should be signed out on the controlled drug record when removed and once administered, the medication administration record should be signed by the nurse. 2. The clinical record for Resident H was reviewed on 7/22/25 at 12:02 p.m. The			

resident's diagnosis included, but was not limited to, insomnia.

The physician's order, dated 12/24/24, indicated the resident was to receive Clonazepam (narcotic medication used for sleep disorders) 0.5 mg (milligrams) every evening at 9:00 p.m.

The June 2025 controlled drug use record indicated the resident received the medication at 9:00 p.m. on 6/2/25, 6/5/25 and 6/16/25.

The June 2025 medication administration record lacked documentation of the administration of the medication.

3. The clinical record for Resident K was reviewed on 7/22/25 at 1:45 p.m. The resident's diagnosis included, but was not limited to, chronic pain syndrome.

The June and July 2025 medication administration record indicated the resident was to receive Oxycodone (narcotic pain medication) 10-325 mg every 4 hours at 12:00 a.m., 6:00 a.m., 12:00 p.m. and 6:00 p.m.

The June and July 2025 controlled drug use record indicated the medication was administered on the following dates and times:

	- 6/07/25 at 12:00 a.m. - 6/08/25 at 12:00 a.m. - 6/09/25 at 12:00 a.m. - 6/12/25 at 6:00 a.m. - 6/16/25 at 6:00 p.m. - 6/29/25 at 12:00 a.m. - 6/30/25 at 12:00 a.m. and 6:00 p.m. - 7/10/25 at 12:00 p.m. - 7/11/25 at 12:00 p.m. - 7/12/25 at 12:00 a.m. and 12:00 p.m. - 7/13/25 at 12:00 a.m. and 12:00 p.m. - 7/16/25 at 12:00 a.m. - 7/17/25 at 12:00 a.m. The June 2025 and July 2025 medication administration record lacked documentation of the administration of the medication. On 7/23/25 at 1:55 p.m., the Clinical Specialist provided a current copy of the document titled "Medication Management, Administration, & Storage" dated 3/2022. It included, but was not limited to, "Documentation...At the time of administration, the licensed nurse or QMA administering the			

	medication will document the administration in the medication...administration record that includes...Name or initials of the person administering the drug...." This citation relates to Complaints IN00461331 and IN00463434.			
R 0272	Food and Nutritional Services - Deficiency 410 IAC 16.2-5-5.1(e) (e) All food shall be served at a safe and appropriate temperature. Based on interview and record review, the facility failed to ensure the evening meal temperatures were documented for 5 of 30 days reviewed for the month of June. This deficient practice had the potential to affect 102 of 102 residents residing in the facility. Findings include: The review of a State reported complaint, dated 6/13/25, indicated food was served to the residents' undercooked from the kitchen. When the chicken was found to be undercooked it was brought back to the kitchen. On 7/22/25 at 9:10 a.m., Dietary Cook 5 provided a clip board which contained the food	R 0272	**1 What corrective action(s) will be accomplished for those residents found to have been affected by the deficient practice;** a **2 How the facility will identify other residents having the potential to be affected by the same deficient practice and what corrective action will be taken;** a All residents had the potential to be affected by the alleged deficient practice. All cooks were educated with the policy of food temperature/recording. All new	08/15/2025

	temperature charts for the month of June 2025. The following days, related to the evening meal, lacked documented temperatures: - On 6/04/25 - No temperatures were documented for the evening meal - On 6/05/25 - No temperatures were documented for the evening meal - On 6/06/25 - No temperatures were documented for the evening meal - On 6/09/25 - No temperatures were documented for the evening meal - On 6/27/25 - No temperatures were documented for the evening meal During an interview, on 7/22/25 at 1:21 p.m., the Dietary Manager indicated the temperature of the food should be completed and documented prior to serving meals. On 7/23/25 at 1:55 p.m., the Clinical Specialist provided a current copy of the document titled "Cooking & Holding Temperatures for Potentially Hazardous Foods" dated 5/2024. It included, but was not limited to, "Responsibility...staff will monitor food temperatures and log sheets daily to make sure proper temperatures are		cook employees will be educated on Food Temp policy with job specific orientation. **3** **What** **measures will be put into place or what systemic changes the facility will make to ensure that the deficient practice does not recur;** a. Cooks were educated on food temp policy; new hire cooks will be educated regarding food temp policy upon job specific orientation; Culinary Director or designee will audit food temp log form daily for compliance; Executive Director or designee will review logs/audit tool weekly for compliance with food temp policy and recording temperatures. **4 How the corrective action(s) will be** **monitored to ensure the deficient practice will not recur, i.e., what quality assurance program will be put into place;**	

	maintained...." This citation relates to Complaints IN00461331, IN00461473, IN00462828 and IN00463434. Based on interview and record review, the facility failed to ensure the evening meal temperatures were documented for 5 of 30 days reviewed for the month of June. This deficient practice had the potential to affect 102 of 102 residents residing in the facility. Findings include: The review of a State reported complaint, dated 6/13/25, indicated food was served to the residents' undercooked from the kitchen. When the chicken was found to be undercooked it was brought back to the kitchen. On 7/22/25 at 9:10 a.m., Dietary Cook 5 provided a clip board which contained the food temperature charts for the month of June 2025. The following days, related to the evening meal, lacked documented temperatures: - On 6/04/25 - No temperatures were documented for the evening meal - On 6/05/25 - No temperatures were documented for the evening meal		a This process will be reviewed by ED/designee on a weekly basis for 8 weeks, monthly for 4 months and as needed thereafter as part of the QA process. b Results will be reviewed as part of the QA process in order to identify any anomalies or potential patterns. If indicated, an action plan will be implemented by QA team and reviewed as needed until resolved. **5** **By** **what date the systemic changes will be completed;** a 8/15/25	

	- On 6/06/25 - No temperatures were documented for the evening meal - On 6/09/25 - No temperatures were documented for the evening meal - On 6/27/25 - No temperatures were documented for the evening meal During an interview, on 7/22/25 at 1:21 p.m., the Dietary Manager indicated the temperature of the food should be completed and documented prior to serving meals. On 7/23/25 at 1:55 p.m., the Clinical Specialist provided a current copy of the document titled "Cooking & Holding Temperatures for Potentially Hazardous Foods" dated 5/2024. It included, but was not limited to, "Responsibility...staff will monitor food temperatures and log sheets daily to make sure proper temperatures are maintained...." This citation relates to Complaints IN00461331, IN00461473, IN00462828 and IN00463434.			
R 0297	Pharmaceutical Services - Noncompliance 410 IAC 16.2-5-6(c)(1) (c) If the facility controls, handles,	R 0297	**1 What corrective action(s) will be accomplished for those residents found to have been**	08/15/2025

	and administers medications for a resident, the facility shall do the following for that resident: (1) Make arrangements to ensure that pharmaceutical services are available to provide residents with prescribed medications in accordance with applicable laws of Indiana. Based on interview and record review, the facility failed to ensure residents' (Residents B and H) medications were available to administer for 2 of 4 residents reviewed for pharmacy services. Findings include: 1. The clinical record for Resident B was reviewed on 7/22/25 at 11:31 a.m. The resident's diagnoses included, but were not limited to, porphyria and anxiety. During an interview, on 7/22/25 at 10:48 a.m., the resident indicated she had missed two doses of her Morphine and had to go to the hospital to get it. She could tolerate missing one dose, but not missing two doses was too much. The progress note, dated 7/20/25 at 10:43 a.m., indicated staff had spoken with pharmacy concerning this resident's morphine, and reported that they did have a script on file for her morphine, however, it would		**affected by the deficient practice; no residents experienced adverse effects from the alleged deficient practice.** a **2** **How** **the facility will identify other residents having the potential to be affected** **by the same deficient practice and what corrective action will be taken;** a All residents that the facility controls, handles and administers medications to had the potential to be affected by the alleged deficient practice. DON and/or designee will audit all residents who receive medications from the pharmacy to ensure timely response and/or updates from the physician. **3** **What** **measures will be put into**	

	have to be sent out the next night which would be 7/21/25 since they did not deliver on the weekends. The resident had both doses on 7/19/25 at 9:00 a.m. and 9:00 p.m. according to controlled drug use record. The resident did not get the medication because the resident was out of the medication. . The progress note, dated 7/20/25 at 8:15 p.m., indicated the resident called EMS (emergency medical services) to transport her to emergency room due to her morphine supply had been depleted. The resident was transported by EMS to the hospital emergency room. The July 2025 medication administration record indicated the resident was to receive morphine 30 mg (milligrams) twice daily at 9:00 a.m. and 9:00 p.m. The July 2025 controlled drug use record indicated the resident last received the morphine on 7/19/25 at 8:00 p.m. The progress note, dated 7/21/25 at 5:20 p.m., indicated the resident's medication had arrived to the facility. During an interview, on 7/23/25 at 1:55 p.m., the Clinical Specialist indicated it was the facility's responsibility to ensure		**place or what systemic changes the facility will make to ensure that the deficient practice does not recur;** a DON and/or designee will audit all pharmacy re-orders, to ensure timely delivery and availability of medications. The Director of Nursing, or designee will educate all newly hired clinical staff, including any agency staff, on policies and protocols during employee job-specific orientation moving forward. **4 How the corrective action(s) will be monitored to ensure the deficient practice will not recur, i.e., what quality assurance program will be put into place;** a Pharmacy re-ordering will be reviewed by DON/designee as they are received as part of the QA process.	

	medications were re-ordered timely so residents can have them. 2. The clinical record for Resident H was reviewed on 7/22/25 at 12:02 p.m. The resident's diagnoses included, but were not limited to insomnia and panic disorder. During an interview, on 7/23/25 at 10:55 a.m., Resident H indicated around July 1, 2025, she did not have her Clonazepam for 4 days. The medication helped her sleep at night and she did not sleep well when she did not get the medication for 4 days in a row. The July 2025 medication administration record indicated the resident was to receive Clonazepam 0.5 mg at bedtime. The progress note, dated 7/3/25 at 3:55 p.m., indicated the facility nurse spoke with the psychiatric nurse and requested a new prescription be sent to the pharmacy for the resident's Clonazepam to be delivered as soon as possible. The July 2025 controlled drug use record indicated Resident last received the medication on 7/1/25 at 8:00 p.m. and did not receive the medication again until 7/5/25 at 9:00 p.m. On 7/23/25 at 1:55 p.m., the Clinical Specialist provided a		b Results will be reviewed as part of the QA process in order to identify any anomalies or potential patterns. If indicated, an action plan will be implemented by QA team and reviewed as needed until resolved. **5** **By** **what date the systemic changes will be completed;** a 8/15/25	

current copy of the document titled "Pharmacy Services" dated 9/2021. It included, but was not limited to, "Policy...Our community controls, handles, and administers medications for a resident if medication management is needed. Medication management includes, but is not to be limited to...Ensuring that pharmaceutical services are available to provide residents with prescribed medications in accordance with applicable laws...."

This citation relates to Complaints IN00461331 and IN00463434

Based on interview and record review, the facility failed to ensure residents' (Residents B and H) medications were available to administer for 2 of 4 residents reviewed for pharmacy services.

Findings include:

1. The clinical record for Resident B was reviewed on 7/22/25 at 11:31 a.m. The resident's diagnoses included, but were not limited to, porphyria and anxiety.

During an interview, on 7/22/25 at 10:48 a.m., the resident indicated she had missed two doses of her Morphine and had to go to the hospital to get it. She could tolerate missing one

	dose, but not missing two doses was too much. The progress note, dated 7/20/25 at 10:43 a.m., indicated staff had spoken with pharmacy concerning this resident's morphine, and reported that they did have a script on file for her morphine, however, it would have to be sent out the next night which would be 7/21/25 since they did not deliver on the weekends. The resident had both doses on 7/19/25 at 9:00 a.m. and 9:00 p.m. according to controlled drug use record. The resident did not get the medication because the resident was out of the medication. . The progress note, dated 7/20/25 at 8:15 p.m., indicated the resident called EMS (emergency medical services) to transport her to emergency room due to her morphine supply had been depleted. The resident was transported by EMS to the hospital emergency room. The July 2025 medication administration record indicated the resident was to receive morphine 30 mg (milligrams) twice daily at 9:00 a.m. and 9:00 p.m. The July 2025 controlled drug use record indicated the resident last received the morphine on 7/19/25 at 8:00			

p.m.

The progress note, dated 7/21/25 at 5:20 p.m., indicated the resident's medication had arrived to the facility.

During an interview, on 7/23/25 at 1:55 p.m., the Clinical Specialist indicated it was the facility's responsibility to ensure medications were re-ordered timely so residents can have them.

2. The clinical record for Resident H was reviewed on 7/22/25 at 12:02 p.m. The resident's diagnoses included, but were not limited to insomnia and panic disorder.

During an interview, on 7/23/25 at 10:55 a.m., Resident H indicated around July 1, 2025, she did not have her Clonazepam for 4 days. The medication helped her sleep at night and she did not sleep well when she did not get the medication for 4 days in a row.

The July 2025 medication administration record indicated the resident was to receive Clonazepam 0.5 mg at bedtime.

The progress note, dated 7/3/25 at 3:55 p.m., indicated the facility nurse spoke with the psychiatric nurse and requested a new prescription be sent to the pharmacy for the resident's Clonazepam to be delivered as

	soon as possible. The July 2025 controlled drug use record indicated Resident last received the medication on 7/1/25 at 8:00 p.m. and did not receive the medication again until 7/5/25 at 9:00 p.m. On 7/23/25 at 1:55 p.m., the Clinical Specialist provided a current copy of the document titled "Pharmacy Services" dated 9/2021. It included, but was not limited to, "Policy...Our community controls, handles, and administers medications for a resident if medication management is needed. Medication management includes, but is not to be limited to...Ensuring that pharmaceutical services are available to provide residents with prescribed medications in accordance with applicable laws...." This citation relates to Complaints IN00461331 and IN00463434			
R 0352	Clinical Records - Noncompliance 410 IAC 16.2-5-8.1(e)(1-4) (e) The clinical record must contain the following: (1) Sufficient information to identify the resident. (2) A record of the resident ' s	R 0352	**1 What corrective action(s) will be accomplished for those residents found to have been affected by the deficient practice; no residents experienced adverse effects from the alleged deficient practice.**	08/15/2025

evaluations.

(3) Services provided.

(4) Progress notes.

Based on interview and record review, the facility failed to ensure residents (Residents C and G) medication administration records were available for review for 2 of 4 residents reviewed for medical records.

Findings include:

1. The closed clinical record for Resident C was reviewed on 7/22/25 at 12:07 p.m. The resident's diagnoses included, but were not limited to, chronic obstructive pulmonary disease, hypertension, hyperlipidemia, benign neoplasm of the adrenal gland, glaucoma, congestive heart failure, chronic gout, chronic kidney disease, cystic disease of the liver and acute embolism and thrombosis of the calf muscular vein.

On 7/22/25 at 9:22 a.m., the resident's medication administration record for June 2025 was requested from the Director of Nursing (DON). She indicated the medication administration records for all the residents were completed on paper due to a system switch over and were currently in a binder. The DON was provided the names of the medication

a **2**
How
the facility will identify other residents having the potential to be affected
by the same deficient practice and what corrective action will be taken;

a All residents had the potential to be
affected by the alleged deficient practice.
DON and/or designee will ensure that medical records are stored in
accordance with the company Medical Records Storage Policy. Employees found to be out of compliance with medication documentation will receive additional education and corrective
action.

	administration records needed for review. On 7/23/25 at 10:22 a.m., the Clinical Support indicated they were still trying to locate Resident C's medication administration record. On 7/23/25 at 2:40 p.m., the Clinical Support indicated they could not locate the June 2025 medication administration record for Resident C. On 7/23/25 at 3:00 p.m., the Clinical Support provided a current copy of the document titled "Chart Thinning Policy" dated 1/2022. It included, but was not limited to, "Resident records are to be broken down and filed upon discharge...Discharged records are to be kept on-site for at least 12 months from discharge...." 2. The clinical record for Resident G was reviewed on 7/22/25 at 12:12 p.m. There were no diagnoses listed in the system for the resident. On 7/22/25 at 9:22 a.m., the resident's medication administration record for June 2025 was requested from the Director of Nursing (DON). She indicated the medication administration records for all the residents were completed on paper for the month of June due to a system switch over and		**3** **What measures will be put into place or what systemic changes the facility will make to ensure that the deficient practice does not recur;** a DON and/or designee will ensure that medical records are stored in accordance with the company Medical Records Storage Policy. Any staff member out of compliance with facility's policies and protocols will receive progressive corrective action, including termination. The Director of Nursing, or designee will educate all newly hired clinical staff, including any agency staff, on policies and protocols during employee job-specific orientation moving forward.	

were currently in a binder. The DON was provided the names of the medication administration records needed for review.

On 7/23/25 at 10:22 a.m., the Clinical Support indicated they were still trying to locate Resident G's medication administration record.

On 7/23/25 at 2:40 p.m., the Clinical Support indicated they could not locate the June 2025 medication administration record for Resident G.

This citation relates to Complaint IN00462828.

Based on interview and record review, the facility failed to ensure residents (Residents C and G) medication administration records were available for review for 2 of 4 residents reviewed for medical records.

Findings include:

1. The closed clinical record for Resident C was reviewed on 7/22/25 at 12:07 p.m. The resident's diagnoses included, but were not limited to, chronic obstructive pulmonary disease, hypertension, hyperlipidemia, benign neoplasm of the adrenal gland, glaucoma, congestive heart failure, chronic gout, chronic kidney disease, cystic disease of the liver and acute embolism and thrombosis of the

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

a This process will be reviewed by ED/designee
on a weekly basis for 8 weeks, monthly for 4 months and as needed thereafter as
part of the QA process.

b Results will be reviewed as part of the QA
process in order to identify any anomalies or potential patterns. If indicated,
an action plan will be implemented by QA team and reviewed as needed until resolved.

5
By
what date the systemic changes will be completed;

	calf muscular vein. On 7/22/25 at 9:22 a.m., the resident's medication administration record for June 2025 was requested from the Director of Nursing (DON). She indicated the medication administration records for all the residents were completed on paper due to a system switch over and were currently in a binder. The DON was provided the names of the medication administration records needed for review. On 7/23/25 at 10:22 a.m., the Clinical Support indicated they were still trying to locate Resident C's medication administration record. On 7/23/25 at 2:40 p.m., the Clinical Support indicated they could not locate the June 2025 medication administration record for Resident C. On 7/23/25 at 3:00 p.m., the Clinical Support provided a current copy of the document titled "Chart Thinning Policy" dated 1/2022. It included, but was not limited to, "Resident records are to be broken down and filed upon discharge...Discharged records are to be kept on-site for at least 12 months from discharge...."		a 8/15/25	

2. The clinical record for Resident G was reviewed on 7/22/25 at 12:12 p.m.

There were no diagnoses listed in the system for the resident.

On 7/22/25 at 9:22 a.m., the resident's medication administration record for June 2025 was requested from the Director of Nursing (DON). She indicated the medication administration records for all the residents were completed on paper for the month of June due to a system switch over and were currently in a binder. The DON was provided the names of the medication administration records needed for review.

On 7/23/25 at 10:22 a.m., the Clinical Support indicated they were still trying to locate Resident G's medication administration record.

On 7/23/25 at 2:40 p.m., the Clinical Support indicated they could not locate the June 2025 medication administration record for Resident G.

This citation relates to Complaint IN00462828.

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