STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTIONS	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
		A. BUILDING B. WING	11/14/2024

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 a State Residential Licensure Survey. This visit included the Investigation of Complaints IN00445609, IN00440252, and IN00447163. Complaint IN00445609 - No deficiencies related to the allegations are cited. Complaint IN00440252 - No deficiencies related to the allegations are cited. Complaint IN00447163 - State deficiency related to the allegations is cited at R0297. Survey date: November 14, 2024. Facility number: 015121 Residential Census: 120 This State Residential Finding is cited in accordance with 410 IAC 16.2-5. Quality review completed on	R 0000	The submission of this plan of correction does not indicate an admission by Vivera Jeffersonville that the finding & allegations contained herein are an accurate true representation of the quality of care provided to the residents of Vivera Jeffersonville. The community hereby maintains it is 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. Vivera Jeffersonville community respectfully requests a desk review/paper compliance for these citations.	

	November 17, 2024.			
R 0297	Pharmaceutical Services - Noncompliance 410 IAC 16.2-5-6(c)(1) (c) If the facility controls, handles, and administers medications for a resident, the facility shall do the following for that resident: (1) Make arrangements to ensure that pharmaceutical services are available to provide residents with prescribed medications in accordance with applicable laws of Indiana. Based on observation, record review and interview, the facility failed to ensure proper use related to priming of the insulin kwikpens for 2 of 3 residents observed for pharmacy services. (Residents J and K) Findings include: 1. During an observation on 11/14/24 at 10:42 a.m., Qualified Medication Aide (QMA) 3 administered 2 units of Humalog subcutaneously to Resident J. The QMA dialed the kwikpen to 2 units per sliding scale without priming (dialing the kwikpen to 2 units and pushing the insulin out of the needle, prior to dialing the insulin to the ordered dose). The resident's blood sugar was 175.	R 0297	What corrective actions will be accomplished for those residents found to have been affected by the deficient practices: The community educated all clinical staff (nursing/QMAs/DON) on Vivera's policy of administration of pharmaceuticals on or before 11/29/24 by documented in-servicing with staff signatures (exhibits A,B,C) How the facility will identify other residents having the potential to be affected by the same deficient practice: all residents who are provided with medication administration services by the facility have the potential to be affected. The community reviewed all residents who use insulin and review their service plans for accuracy. The community educated all clinical staff (nursing/QMAs/DON) on Vivera's policy of administration of pharmaceuticals on or before 11/29/24 by documented in servicing with staff signatures (exhibit C) What measures will be put into place or what systematic changes the facility will make to ensure that the deficient practice does not reoccur: the DON and or designee will audit nursing staff weekly for 4 weeks (until all staff are audited) then audit twice a month for two months, then monthly thereafter to ensure compliance. See Attached	11/29/2024

	During an interview on 11/14/24 at 11:53 a.m., QMA 3 indicated she usually primed the needle prior to administering the insulin, but didn't prime it this time. She would prime the needle to get the excess air bubbles out of the needle. 2. During an observation on 11/14/24 at 11:38 a.m., the DON (Director of Nursing) administered 7 units of Humalog subcutaneously to Resident K. The DON dialed the kwikpen to 7 units without priming the needle. She had initially indicated she would administer 12 units of insulin total and the resident stopped her and indicated that was not correct. The DON read the order again on her computer and indicated the resident was correct and that 7 units would be administered. The resident's blood sugar reading was 166. The physician's order, dated 2/11/23, indicated staff were to administer the resident's Humalog per sliding scale if the blood sugar was between 151 and 200 give 2 units. If the blood sugar was between 201 and 250 give 3 units. If the blood sugar was between 251 and 300 give 4 units. If the blood sugar was between 301 and 350 give 5 units. If the blood sugar was between 351 and 400 give 6 units. If the blood sugar was 401 or higher		exhibit A & B which includes priming the pen/needle. How the corrective actions will be monitored to ensure the deficient practice will not reoccur: The DON and or designee will audit nursing shift weekly for 4 weeks, then audit twice a month for two months and then monthly thereafter to ensure compliance. this includes reviewing MAR for correct dosage, and priming insulin. Anyone not in compliance will be educated immediately. Results will be reviewed by the DON/ED and placed on the Quality Assurance team log to be discussed during monthly QA meetings. The systematic changes will be complete by November 29th 2024.	

give 8 units and call the doctor. The sliding scale was to be administered before meals and at bedtime.

The physician's order, dated 11/20/23, indicated to administer 5 units of Humalog kwikpen subcutaneously three times daily before meals for hyperglycemia.

During an interview on 11/14/24 at 11:46 a.m., the DON indicated she did not prime the needle. She indicated she and the QMA should have primed the needles prior to dialing the kwikpens to the ordered doses. Priming the needle would push the air out of the needle before the administration of the insulin. She was not sure if the facility had a policy on priming an insulin flexpen prior to administration.

The DON provided the current Good RX insulin administration policy on 11/14/24 at 2:03 p.m. The policy included, but was not limited to, "... Prepare your insulin pen 7. If you're using a new pen for the first time, dial up 1 to 2 units. Press the injection button to let out any air bubbles (called 'priming'). If you see a small drop of insulin come out the tip of the pen, it's ready to use.

This citation was related to Complaint IN00447163

Based on observation, record review and interview, the facility failed to ensure proper use related to priming of the insulin kwikpens for 2 of 3 residents observed for pharmacy services. (Residents J and K)

Findings include:

1. During an observation on 11/14/24 at 10:42 a.m., Qualified Medication Aide (QMA) 3 administered 2 units of Humalog subcutaneously to Resident J. The QMA dialed the kwikpen to 2 units per sliding scale without priming (dialing the kwikpen to 2 units and pushing the insulin out of the needle, prior to dialing the insulin to the ordered dose). The resident's blood sugar was 175.

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During an interview on 11/14/24 at 11:46 a.m., the DON indicated she did not prime the needle. She indicated she and the QMA should have primed the needles prior to dialing the kwikpens to the ordered doses.

	Priming the needle would push the air out of the needle before the administration of the insulin. She was not sure if the facility had a policy on priming an insulin flexpen prior to administration. The DON provided the current Good RX insulin administration policy on 11/14/24 at 2:03 p.m. The policy included, but was not limited to, "... Prepare your insulin pen 7. If you're using a new pen for the first time, dial up 1 to 2 units. Press the injection button to let out any air bubbles (called 'priming'). If you see a small drop of insulin come out the tip of the pen, it's ready to use. This citation was related to Complaint IN00447163			

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