

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 08/25/2026	
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 was for the Investigation of Intake 471325. Intake 471325 - State deficiency related to the allegations is cited at R0240. Survey date: August 25, 2026 Facility number: 015121 Residential Census: 103 This State Residential Finding is cited in accordance with 410 IAC (Indiana Administrative Code) 16.2-5. Quality review completed on September 8, 2026.	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 0240	Health Services - Deficiency 410 IAC 16.2-5-4(d) (d) Personal care, and assistance with activities of daily living, shall be provided based upon individual needs and preferences.	R 0240	R240	09/10/2026			

Based on interview and record review, the facility failed to ensure ADL (Activities of Daily Living) care and safety checks were provided to residents (Resident B, Resident C and Resident D) for 3 of 3 residents that resided on the memory care unit.

Findings include:

1. The clinical record for Resident B was reviewed on 8/25/26 at 9:59 a.m. The resident's diagnoses included, but were not limited to, dementia (a loss of memory, language, problem-solving, and thinking abilities) and benign prostatic hyperplasia (enlargement of the prostate gland).

The Incident Report, dated 8/4/26 at 7:45 a.m., indicated Resident B's family had concerns about the care he had received from Certified Nurse Aide (CNA 3), on night shift, between 6:00 p.m. on 8/2/26 through 6:00 a.m. on 8/3/26.

The service plan, dated 3/16/26, indicated the resident had no bladder control, multiple daily incontinent episodes and required assistance with incontinent care.

The August 2026 ADL task

• What corrective action(s) will be accomplished for those residents found to have been affected by the deficient practice;

(d) The resident found to be involved with the potentially deficient practice was transported to the hospital and was evaluated, and found to have sustained no injury related to the potential deficient practice. When the resident returns the resident will receive documented and proper assistance required by the resident's specific plan of care.

• 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;

(d) All residents requiring proper assistance with activities of daily living (ADL) and documentation of safety checks, 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 ADL in real time in the EMR. Employees found to be out of compliance with properly documenting will receive additional education and possible corrective action.

• What measures will be put

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record indicated toileting reminders and safety checks were to be completed every 2 hours, on night shift as follows:

8/2/26, between 6:00 p.m. and 7:00 p.m.

8/2/26, between 8:00 p.m. and 9:00 p.m.

8/2/26, between 10:00 p.m. and 11:00 p.m.

8/3/26, between 12:00 a.m. and 1:00 a.m.

8/3/26, between 2:00 a.m. and 3:00 a.m.

8/3/26, between 4:00 a.m. and 5:00 a.m.

The clinical record lacked documentation of any safety checks or care provided between 8/2/26 at 6:00 p.m. and 8/3/26 at 5:00 a.m. for Resident B.

During an interview, on 8/25/26 at 11:02 a.m., the Assistant Director of Nursing (ADON) indicated, on the memory care unit, safety checks were to be completed every 2 hours on all the residents and documented on the task record. The ADON indicated she had viewed the video surveillance from 8/2/26 at 6:00 p.m. through 8/3/26 at 6:00 a.m. CNA 3 did not enter Resident B's room the entire

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

(d) An in-service will be held by the Director of Nursing for all Clinical Staff. 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 relating to proper documentation of assistance with ADL care and proper safety checks during employee job-specific orientation moving forward.

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

(d) 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

• How the corrective action(s)

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shift to provide any care or safety checks nor did she complete safety checks on any of the residents.

2. The clinical record for Resident C was reviewed on 8/25/26 at 1:22 p.m. The resident's diagnoses included, but were not limited to, cognitive communication deficit (a breakdown in communication caused by impaired thinking skills like attention, memory, and problem solving) and memory deficit (inability to store, retain, or recall information).

The August 2026 ADL task record indicated safety checks were to be completed every 2 hours, on night shift as follows:

8/2/26, between 6:00 p.m. and 7:00 p.m.

8/2/26, between 8:00 p.m. and 9:00 p.m.

8/2/26, between 10:00 p.m. and 11:00 p.m.

8/3/26, between 12:00 a.m. and 1:00 a.m.

8/3/26, between 2:00 a.m. and 3:00 a.m.

8/3/26, between 4:00 a.m. and 5:00 a.m.

The clinical record lacked documentation of any safety

will be monitored to ensure the deficient practice will not recur, i.e., what quality assurance program will be put into place; and by what date the systemic changes will be completed.

(d) Education and in-service will be provided to all clinical staff by or on 9/18/2026

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checks completed on 8/2/26 at 6:00 p.m. through 8/3/26 at 5:00 a.m. for Resident C.

3. The clinical record for Resident D was reviewed on 8/25/26 at 1:34 p.m. The resident's diagnoses included, but were not limited to, mild cognitive impairment (transitional stage between normal age-related memory loss and more serious conditions like dementia) and cerebral infarction (a serious medical emergency that happens when a blocked blood vessel stops blood and oxygen from reaching part of the brain, causing brain tissue to die).

The August 2026 ADL task record indicated safety checks were to be completed every 2 hours, on night shift as follows:

8/2/26, between 6:00 p.m. and 7:00 p.m.

8/2/26, between 8:00 p.m. and 9:00 p.m.

8/2/26, between 10:00 p.m. and 11:00 p.m.

8/3/26, between 12:00 a.m. and 1:00 a.m.

8/3/26, between 2:00 a.m. and 3:00 a.m.

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8/3/26, between 4:00 a.m. and 5:00 a.m.

The clinical record lacked documentation of any safety checks completed on 8/2/26 at 6:00 p.m. through 8/3/26 at 5:00 a.m. for Resident D.

This citation relates to Intake 471235.

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
SIGNATUREDavid Burkholder

TITLEExecutive Director

(X6) DATE09/18/2026