STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	155695	A. BUILDING 00 B. WING	10/10/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP COD
RIVERSIDE VILLAGE	1400 W FRANKLIN ST ELKHART, IN 46516

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F 0000 Bldg. 00	This visit was for the Investigation of Complaints IN00443234, IN00440483, IN00440408 and IN00438192. Complaint IN00443234 - No deficiencies related to the allegations are cited. Complaint IN00440483 - No deficiencies related to the allegations are cited. Complaint IN00440408 - No deficiencies related to the allegations are cited. Complaint IN00438192 - Federal/State deficiencies related to the allegations are cited at F580, F684, & F755 Survey dates: October 9 & 10, 2024 Facility number: 003075 Provider number: 155695 AIM number: 200364160 Census Bed Type: SNF/NF: 70 Total: 70 Census Payor Type: Medicaid: 40 Other: 30 Total: 70 These deficiencies reflect State Findings cited in accordance with 410 IAC 16.2-3.1. Quality Review completed on 10/16/2024	F 0000		

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE	TITLE	(X6) DATE
Tarshia Taylor	Executive Director	10/29/2024

Any defiencystatement ending with an asterisk (*) denotes a deficency which the institution may be excused from correcting providing it is determin other safegaurds provide sufficient protection to the patients. (see instructions.) Except for nursing homes, the findings stated above are disclosable following the date of survey whether or not a plan of correction is provided. For nursing homes, the above findings and plans of correction are disclo days following the date these documents are made available to the facility. If deficiencies are cited, an approved plan of correction is requisite to continued program participation.

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F 0580 SS=D Bldg. 00	483.10(g)(14)(i)-(iv)(15) Notify of Changes (Injury/Decline/Room, etc.) Based on interview and record review, the facility failed to notify the physician of multiple missed medication administrations for 1 of 3 residents reviewed for notification. (Resident C) Finding includes: The clinical record for Resident C was reviewed on 10/9/24 at 3:37 P.M. Diagnosis included, but were not limited to, Bipolar II disorder, borderline personality, anxiety, obsessive-compulsive disorder and chronic low back pain. Physician's Orders dated 6/10/24 to 7/2/24, indicated Resident C's prescribed orders included: Baclophen one 10 mg tablet four times a day with meals and at bedtime at 8:00 A.M., 12:00 P.M., 5:00 P.M., and 9:00 P.M., for chronic back pain, with a start date of 6/10/24 and end date of 8/12/24. Caplyta one 42 mg capsule once a day in the evenings between 7:00 P.M. and 10:00 P.M., for Bipolar II disorder, with a start date of 6/10/24 and end date of 8/12/24. Pregabalin one 100 mg capsule two times a day in the morning between 7:00 A.M. and 10:00 A.M. and again between 7:00 P.M. and 10:00 P.M., for chronic back pain with a start date of 6/10/24 and end date 6/20/24. A review of Resident C's Medication Administration Record (MAR) from 6/10/24 to 7/2/24, indicated the resident did not receive the prescribed medications on the following dates and times: Baclophen one 10 mg tablet four times a day with meals and at bedtime on 6/11/24 at 5:00 P.M., 6/17/24 at 8:00 A.M., 6/28, 19, 23, 2024 at 5:00 P.M.,	F 0580	F580- Notification of Changes What corrective action(s) will be accomplished for those residents found to have been affected by the deficient practice: Resident C has discharged from the facility. How other residents having the potential to be affected by the same deficient practice will be identified and what corrective action(s) will be taken: All residents have the potential to be affected. DNS/designee will have an inservice with nurses on physician notification of an unavailable med. What measures will be put into place or what systemic changes will be made to ensure that the deficient practice does not recur: The DNS/designee will in-service all nurses on physician notification of unavailable medication on or before 11.8.24 During AM clinical meeting, DNS/designee will review the Medication Administration Compliance report daily for unavailable meds and verify that the physician was notified. Any concerns will be addressed immediately. 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:	11/08/2024

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	and 6/27/24 at 9:00 P.M. There were no nursing comments to indicated why the resident had not received the medication. Caplyta on 6/11/24 at 6/11/24, 6/12/24, 6/18/24, 6/19/24, and 6/23/24 at 7:00 P.M. - 10:00 P.M. The nursing comment on the MAR indicated, "Not Administer: Drug/Item Unavailable," each time the medication was not administered. Pregabalin on 6/11/24 at 7:00 A.M. to 11:00 A.M. and 7:00 P.M. - 11:00 P.M., 6/12/24 at 7:00 A.M. to 11:00 A.M. and 7:00 P.M. - 11:00 P.M. The nursing comment on the MAR indicated "Not Administer: Drug/Item Unavailable," each time the medication was not administered. Review of the pharmacy "Proof of Delivery" statement indicated the resident's Baclophen was shipped from the pharmacy on 6/10/24 and received by the facility on 6/11/24 at 1:23 A.M., The Caplyta medication was shipped from the pharmacy on 6/12/24 and received by the facility on 6/13/24 at 12:47 A.M., and Pregabalin medication was shipped from the pharmacy on 6/12/24 and received by the facility on 6/13/24 at 12:47 A.M. During an interview on 10/10/24 at 10:39 A.M., the Director of Nursing indicated an order was sent to the pharmacy for Resident C's Caplyta in a timely manor, but the medication did not come immediately. The Director of Nursing indicated if medications were not immediately available for administration, the physician should be notified for further instructions and the MAR should reflect the reason the medication was not administered. The Director of Nursing indicated the physician should have been notified when Resident C did not receive medication administrations as ordered.		Ongoing compliance with this corrective action will be monitored through the facility Quality Assurance and Performance Improvement Program (QAPI). The DNS/designee will be responsible for completing the QAPI Audit tool “Physician Notification” weekly for 4 weeks, monthly for 6 months and quarterly thereafter for at least 2 quarters. If threshold of 90% is not met, an action plan will be developed. Findings will be submitted to the QAPI Committee for review and follow up By what date the systemic changes will be completed: Compliance Date: 11.8.2	

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	During an interview on 10/10/24 at 1:44 P.M., the Regional Nurse Consultant indicated the physician should have been notified when the resident did not receive medications per physician orders. On 10/10/24 at 1:30 P.M., the Regional Nurse Consultant provided a policy titled, "Medication Shortages/Unavailable Medications," dated 12/1/10 and revised on 1/01/22, and again on 8/1/24, indicating it was the current facility policy. The policy indicated if the available delivery of a medication causes delay or a missed dose in the resident's medication schedule, the facility nurse should obtain the medication from the Emergency Medication Supply to administer the dose, If an emergency delivery was unavailable, The facility nurse was to contact the attending physician to obtain new orders or directions for alternate administration. This citation relates to Complaint IN00438192. 3.1-5(a)(3)			
F 0684 SS=D Bldg. 00	483.25 Quality of Care Based on interview and record review, the facility failed to ensure 1 of 3 residents reviewed for medication administration, received medications as ordered by the resident's physician, (Resident C). Finding includes: The clinical record for Resident C was reviewed on 10/9/24 at 3:37 P.M. Diagnosis included Bipolar II disorder, borderline personality, anxiety, obsessive-compulsive disorder and chronic low	F 0684	**F684- Quality of Care** **What corrective action(s) will be accomplished for those residents found to have been affected by the deficient practice:** **Resident C has been discharged from the facility.** **How other residents having the potential to be affected by the same deficient practice will be identified and what**	11/08/2024

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	back pain. Physician's Orders dated 6/10/24 to 7/2/24 indicated Resident C's prescribed orders included the following medications: Baclophen one 10 mg tablet four times a day with meals and at bedtime at 8:00 A.M., 12:00 P.M., 5:00 P.M., and 9:00 P.M., for chronic back pain, with a start date of 6/10/24 and end date of 8/12/24. Caplyta one 42 mg capsule once a day in the evenings between 7:00 P.M. and 10:00 P.M., for Bipolar II disorder, with a start date of 6/10/24 and end date of 8/12/24. Pregabalin one 100 mg capsule two times a day in the morning between 7:00 A.M. and 10:00 A.M. and again between 7:00 P.M. and 10:00 P.M., for chronic back pain with a start date of 6/10/24 and end date 6/20/24. A review of Resident C's Medication Administration Record (MAR) from 6/10/24 to 7/2/24, indicated the resident did not receive medications on the following dates and times: Baclophen one 10 mg tablet four times a day with meals and at bedtime on 6/11/24 at 5:00 P.M., 6/17/24 at 8:00 A.M., 6/28, 19, 23, 2024 at 5:00 P.M., and 6/27/24 at 9:00 P.M. There were no nursing comments to indicated why the resident had not receive the medication. Caplyta on 6/11/24 at 6/11/24, 6/12/24, 6/18/24, 6/19/24, and 6/23/24 at 7:00 P.M. - 10:00 P.M. The nursing comment on the MAR indicated, "Not Administer: Drug/Item Unavailable," each time the medication was not administered. Pregabalin on 6/11/24 at 7:00 A.M. to 11:00 A.M. and 7:00 P.M. - 11:00 P.M., 6/12/24 at 7:00 A.M. to 11:00 A.M. and 7:00 P.M. - 11:00 P.M. The nursing comment on the MAR indicated "Not Administer: Drug/Item Unavailable," each time the medication was not administered.		**corrective action(s) will be taken:** **All residents have the potential to be affected. DNS/designee will have an in-service with nurses and QMAs on administration of physician prescribed medications.** **What measures will be put into place or what systemic changes will be made to ensure that the deficient practice does not recur:** **The DNS/designee will in-service all nurses and QMAS on administration of physician prescribed medications on or before 11.8.24. During AM clinical meeting, DNS/designee will review the Medication Administration Compliance report to ensure medications have been administered. Any concerns will be addressed immediately.** **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:** **Ongoing compliance with this corrective action will be monitored through the facility Quality Assurance and Performance Improvement Program (QAPI). The DNS/designee will be responsible for completing the**	

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	Review of the pharmacy "Proof of Delivery" statement indicated the resident's Baclophen was shipped from the pharmacy on 6/10/24 and received by the facility on 6/11/24 at 1:23 A.M., Caplyta was shipped from the pharmacy on 6/12/24 and received by the facility on 6/13/24 at 12:47 A.M., and Pregabalin was shipped from the pharmacy on 6/12/24 and received by the facility on 6/13/24 at 12:47 A.M. During an interview on 10/10/24 at 10:39 A.M., the Director of Nursing indicated an order was sent to the pharmacy for Resident C's Caplyta in a timely manor, but the medication did not come immediately. The Director of Nursing indicated if medications were not immediately available for administration, the physician should be notified for further instructions and the MAR should reflect the reason the medication was not administered. During an interview on 10/10/24 at 1:44 P.M., the Regional Nurse Consultant indicated the facility did not carry Caplyta in the emergency medication supply and the physician should have been notified when the resident did not receive medications per physician orders. On 10/10/24 at 1:30 P.M., the Regional Nurse Consultant provided a policy titled, "Medication Shortages/Unavailable Medications," dated 12/1/10 and revised on 1/01/22, and again on 8/1/24, indicating it was the current facility policy. The policy indicated the following: " Upon discovery that Facility has an inadequate supply of a medication to administer to a resident, Facility staff should immediately initiate action to obtain the medication from Pharmacy. If the available delivery causes delay or a missed dose in the		**QAPI Audit tool "Medication Administration" weekly for 4 weeks, monthly for 6 months and quarterly thereafter for at least 2 quarters. If a threshold of 90% is not met, an action plan will be developed. Findings will be submitted to the QAPI Committee for review and follow-up** **By what date the systemic changes will be completed:** **Compliance Date: 11.8.24**	

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	resident's medication schedule, Facility nurse should obtain the medication from the Emergency Medication Supply to administer the dose, and if the medication is not available in the Emergency Medication Supply, Facility staff should notify Pharmacy and arrange for a STAT "immediate" delivery if medically necessary. If an emergency delivery is unavailable, Facility nurse should contact the attending physician to obtain new orders or directions for alternate administration. " The National Library of Medicine indicated in "Nursing Rights of Medication Administration" dated 9/4/23, indicated, It was a standard during nursing education to receive instruction on a guide to clinical medication administration and upholding patient safety known as the ' five rights ' or ' five R ' s ' of medication administration, Right Patient, Right Drug, Right Route, Right Dose and Right time. The right time meaning administering medications at a time that was intended by the prescriber. Often, certain drugs have specific intervals or window periods during which another dose should be given to maintain a therapeutic effect or level. This citation relates to Complaint IN00438192. 3.1-37(a)			
F 0755 SS=D Bldg. 00	483.45(a)(b)(1)-(3) Pharmacy Srvcs/Procedures/Pharmacist/Records Based on interview and record review, the facility failed to ensure 1 of 3 residents reviewed for medication administration, had medications available from the pharmacy in a timely manor, (Resident C). Finding includes:	F 0755	**F755- Pharmacy Services What corrective action(s) will be accomplished for those residents found to have been affected by the deficient practice:** **Resident C has been**	11/08/2024

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	The clinical record for Resident C was reviewed on 10/9/24 at 3:37 P.M. Diagnosis included Bipolar II disorder, borderline personality, anxiety, obsessive-compulsive disorder, and chronic low back pain. The Physician's Orders, dated 6/10/24 to 7/2/24, indicated Resident C's prescribed orders included the following: Caplyta one 42 mg capsule once a day in the evenings between 7:00 P.M. and 10:00 P.M., for Bipolar II disorder, with a start date of 6/10/24 and end date of 8/12/24. Pregabalin one 100 mg capsule two times a day in the morning between 7:00 A.M. and 10:00 A.M. and again between 7:00 P.M. and 10:00 P.M., for chronic back pain with a start date of 6/10/24 and end date 6/20/24. A review of Resident C's Medication Administration Record (MAR) from 6/10/24 to 7/2/24, indicated the resident did not receive the Caplyta medication on 6/11/24 at 6/11/24, 6/12/24, 6/18/24, 6/19/24, and 6/23/24 for the 7:00 P.M. - 10:00 P.M dose. The nursing comment on the MAR indicated, "Not Administer: Drug/Item Unavailable," each time the medication was not administered. Pregabalin on 6/11/24 at 7:00 A.M. to 11:00 A.M. and 7:00 P.M. - 11:00 P.M., 6/12/24 at 7:00 A.M. to 11:00 A.M. and 7:00 P.M. - 11:00 P.M. The nursing comment on the MAR indicated "Not Administer: Drug/Item Unavailable," each time the medication was not administered. Review of the pharmacy "Proof of Delivery" statement indicated the resident's Caplyta was shipped from the pharmacy on 6/12/24 and received by the facility on 6/13/24 at 12:47 A.M.		**discharged from the facility.** **How other residents having the potential to be affected by the same deficient practice will be identified and what corrective action(s) will be taken:** **All residents have the potential to be affected. DNS/designee will have an in-service with nurses and QMAS on pharmacy services and medication availability.** **What measures will be put into place or what systemic changes will be made to ensure that the deficient practice does not recur:** **The DNS/designee will in-service all nurses and QMAS on pharmacy services and medication availability on or before 11.8.24. During AM clinical meeting, DNS/designee will review the Medication Administration Compliance report to ensure that all medications were given and received from pharmacy. Any concerns will be addressed immediately.** **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: Ongoing compliance with this corrective action will be monitored through the facility Quality**	

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	and Pregabalin was shipped from the pharmacy on 6/12/24 and received by the facility on 6/13/24 at 12:47 A.M. During an interview on 10/10/24 at 10:39 A.M., the Director of Nursing indicated an order was sent to the pharmacy for Resident C's Caplyta medication in a timely manor, but the medication did not come immediately. The Director of Nursing indicated if medications were not immediately available for administration, the physician should be notified for for further instructions and the MAR should reflect the reason the medication was not administered. During an interview on 10/10/24 at 1:44 P.M., the Regional Nurse Consultant indicated the facility did not carry Caplyta in the emergency medication supply and the physician should have been notified when the resident did not receive medications per physician orders. On 10/10/24 at 1:30 P.M., the Regional Nurse Consultant provided a policy titled, "Medication Shortages/Unavailable Medications," dated 12/1/10 and revised on 1/01/22, and again on 8/1/24, indicating it was the current facility policy. The policy indicated the following: "... Upon discovery that Facility has an inadequate supply of a medication to administer to a resident, Facility staff should immediately initiate action to obtain the medication from Pharmacy. If the available delivery causes delay or a missed dose in the resident's medication schedule, Facility nurse should obtain the medication from the Emergency Medication Supply to administer the dose, and if the medication is not available in the Emergency Medication Supply, Facility staff should notify Pharmacy and arrange for a STAT "immediate" delivery if medically necessary. If an emergency		**Assurance and Performance Improvement Program (QAPI). The DNS/designee will be responsible for completing the QAPI Audit tool "Unavailable Medications" weekly for 4 weeks, monthly for 6 months and quarterly thereafter for at least 2 quarters. If a threshold of 90% is not met, an action plan will be developed. Findings will be submitted to the QAPI Committee for review and follow-up.** **By what date the systemic changes will be completed:** **Compliance Date: 11.8.24**	

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	delivery is unavailable, Facility nurse should contact the attending physician to obtain new orders or directions for alternate administration. ..." This citation relates to Complaint IN00438192. 3.1-25(a)			