

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

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER 155695	(X2) MULTIPLE CONSTRUCTION A. BUILDING <u>01</u> B. WING _____	(X3) DATE SURVEY COMPLETED 02/03/2025
NAME OF PROVIDER OR SUPPLIER RIVERSIDE VILLAGE		STREET ADDRESS, CITY, STATE, ZIP COD 1400 W FRANKLIN ST ELKHART, IN 46516		
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIE (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
K 0000 Bldg. 01	<p>A Post Survey Revisit (PSR) to the Life Safety Code Recertification and State Licensure Survey conducted on 12/16/24 was conducted by the Indiana Department of Health in accordance 42 CFR Subpart 483.90(a).</p> <p>Survey Date: 02/03/25</p> <p>Facility Number: 003075 Provider Number: 155695 AIM Number: 200364160</p> <p>At this PSR survey, Riverside Village was found not in compliance with Requirements for Participation in Medicare/Medicaid, 42 CFR Subpart 483.90(a), Life Safety from Fire and the 2012 edition of the National Fire Protection Association (NFPA) 101, Life Safety Code (LSC), Chapter 19, Existing Health Care Occupancies and 410 IAC 16.2.</p> <p>This one story facility with a partial basement was determined to be of Type V (111) construction and was fully sprinklered. The facility has a fire alarm system with smoke detection in the corridors, spaces open to the corridors and battery operated smoke alarms were installed in the resident rooms. The building is fully protected by a 250 kW diesel powered emergency generator. The facility has a capacity of 97 and had a census of 79 at the time of this survey.</p> <p>All areas where residents have customary access were sprinklered. All areas providing facility services were sprinklered except a detached shed used for storage.</p>	K 0000		

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE

TITLE

(X6) DATE

Tashia Taylor

Executive Director

02/17/2025

Any deficiency statement ending with an asterisk (*) denotes a deficiency which the institution may be excused from correcting providing it is determined other safeguards 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 disclosed 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.

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

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER 155695	(X2) MULTIPLE CONSTRUCTION A. BUILDING <u>01</u> B. WING _____	(X3) DATE SURVEY COMPLETED 02/03/2025
NAME OF PROVIDER OR SUPPLIER RIVERSIDE VILLAGE		STREET ADDRESS, CITY, STATE, ZIP COD 1400 W FRANKLIN ST ELKHART, IN 46516		
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIE (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
K 0741 SS=E Bldg. 01	<p>Quality Review completed on 02/05/25</p> <p>NFPA 101 Smoking Regulations</p> <p>Based on observation and interview, the facility failed to ensure 1 of 1 smoking areas and 1 of 1 non-smoking areas were maintained by disposing cigarette butts in a metal or noncombustible container with self-closing cover devices. This deficient practice could affect staff outside the kitchen and in the smoking area.</p> <p>Findings include:</p> <p>Based on observation with the Maintenance Director on 01/03/25 at 12:18 p.m. the following cigarette butts were not properly disposed:</p> <p>a.) Outside the kitchen exit (a non-smoking area) there were 10 cigarette butts disposed onto the ground</p> <p>b.) In the staff smoking area there were over 20 cigarette butts disposed onto the ground and the two smoking pole's covers were not secured to the container.</p> <p>Based on an interview at the time of observations, the Maintenance Director agreed there were cigarette butts on the ground in both areas.</p> <p>This finding was reviewed with the Administrator and the Maintenance Director during the exit conference.</p> <p>This deficiency was cited on 12/16/24. The facility failed to implement a systemic plan of correction to prevent recurrence.</p> <p>3.1-19(b)</p>	K 0741	<p>K741- Smoking Regulations</p> <p>What corrective action(s) will be accomplished for those residents found to have been affected by the deficient practice:</p> <p>All cigarette butts were removed and the smoking disposal containers were latched shut.</p> <p>How other residents having the potential to be affected by the same deficient practice will be identified and what corrective actions will be taken:</p> <p>All areas were observed for cigarette butts disposed of onto the ground. No other concerns noted.</p> <p>What measures will be put in place or what systemic changes will be made to ensure that deficient practice does not recur:</p> <p>Staff were educated on proper disposal of smoking materials into approved containers and where the smoking areas are located around the facility.</p> <p>The QAPI and monthly calendar was updated for the Executive Director/Maintenance Director to inspect the smoking area to ensure compliance.</p> <p>How the corrective action(s) will be monitored to ensure the</p>	02/17/2025

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER 155695	(X2) MULTIPLE CONSTRUCTION A. BUILDING <u>01</u> B. WING _____	(X3) DATE SURVEY COMPLETED 02/03/2025
NAME OF PROVIDER OR SUPPLIER RIVERSIDE VILLAGE		STREET ADDRESS, CITY, STATE, ZIP COD 1400 W FRANKLIN ST ELKHART, IN 46516		
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIE (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
			<p>deficient practice will not recur, i.e., what quality assurance program will be put in place: The Executive Director will round the Maintenance Director daily prior to the compliance date to ensure that the smoking area is free from improper smoking materials. The Maintenance Director/Designee will round outside of the building daily of week one, weekly for three weeks, and then monthly. Any findings will be addressed immediately and education provided. The Executive Director will review the preventative maintenance checks performed by the Maintenance Director monthly and sign off that checks have been completed</p> <p>By what date the systemic changes will be completed: 2/17/25.</p>	