

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  155695	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED  10/10/2024
NAME OF PROVIDER OR SUPPLIER  Riverside Village		STREET ADDRESS, CITY, STATE, ZIP CODE  1400 W Franklin St Elkhart, IN 46516	

For information on the nursing home's plan to correct this deficiency, please contact the nursing home or the state survey agency.

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
<p>F 0580</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Immediately tell the resident, the resident's doctor, and a family member of situations (injury/decline/room, etc.) that affect the resident.</p> <p>34966</p> <p>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)</p> <p>Finding includes:</p> <p>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.</p> <p>Physician's Orders dated 6/10/24 to 7/2/24, indicated Resident C's prescribed orders included:</p> <p>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.</p> <p>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.</p> <p>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.</p> <p>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:</p> <p>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 received the medication.</p> <p>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.</p> <p>The nursing comment on the MAR indicated, Not Administer: Drug/Item Unavailable, each time the medication was not administered.</p> <p>(continued on next page)</p>

Any deficiency statement ending with an asterisk (\*) denotes a deficiency which the institution may be excused from correcting providing it is determined that other safeguards provide sufficient protection to the patients. (See instructions.) Except for nursing homes, the findings stated above are disclosable 90 days 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 disclosable 14 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.

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE	TITLE	(X6) DATE
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<p>F 0580</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>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.</p> <p>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.</p> <p>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.</p> <p>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.</p> <p>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.</p> <p>This citation relates to Complaint IN00438192.</p> <p>3.1-5(a)(3)</p>		

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<p>F 0684</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Provide appropriate treatment and care according to orders, resident's preferences and goals.</p> <p>34966</p> <p>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).</p> <p>Finding includes:</p> <p>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.</p> <p>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.</p> <p>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.</p> <p>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.</p> <p>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:</p> <p>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.</p> <p>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.</p> <p>The nursing comment on the MAR indicated, Not Administer: Drug/Item Unavailable, each time the medication was not administered.</p> <p>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.</p> <p>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.</p> <p>(continued on next page)</p>		

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<p>F 0684</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>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.</p> <p>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.</p> <p>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 delivery is unavailable, Facility nurse should contact the attending physician to obtain new orders or directions for alternate administration.</p> <p>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.</p> <p>This citation relates to Complaint IN00438192.</p> <p>3.1-37(a)</p>		

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<p>F 0755</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Provide pharmaceutical services to meet the needs of each resident and employ or obtain the services of a licensed pharmacist.</p> <p>34966</p> <p>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).</p> <p>Finding includes:</p> <p>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.</p> <p>The Physician's Orders, dated 6/10/24 to 7/2/24, indicated Resident C's prescribed orders included the following:</p> <p>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.</p> <p>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.</p> <p>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.</p> <p>The nursing comment on the MAR indicated, Not Administer: Drug/Item Unavailable, each time the medication was not administered.</p> <p>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.</p> <p>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. 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.</p> <p>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 further instructions and the MAR should reflect the reason the medication was not administered.</p> <p>(continued on next page)</p>		

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<p>F 0755</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>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.</p> <p>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 delivery is unavailable, Facility nurse should contact the attending physician to obtain new orders or directions for alternate administration.</p> <p>This citation relates to Complaint IN00438192.</p> <p>3.1-25(a)</p>		