STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	155695	A. Building B. Wing	03/06/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Riverside Village	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)
F 0622 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Not transfer or discharge a resident without an adequate reason; and must provide documentation and convey specific information when a resident is transferred or discharged. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on interview and record review, the facility failed to ensure discharge documentation was obtained and/or complete upon discharge for 5 of 6 residents reviewed for transfer/discharge. (Residents F, H, J, K and L) Finding include: 1. The record for Resident F was reviewed on 3/5/2025 at 10:48 A.M. Diagnoses included, but were not limited to low back pain, Cerebral palsy, obesity and contracture to the right upper arm. A Social Service Progress Note, dated 2/11/2025 at 10:20 A.M., indicated the following: Discharge to preferred address. Resident was alert and oriented. All personal possessions sent with the resident. Resident F's physician orders lacked an order to discharge the resident. During an interview, on 3/6/2025 at 9:56 A.M., the Regional Director of Clinical Services (RDCS) indicated there should have been a physician's order to discharge the resident home. 2. The record for Resident H was reviewed on 3/5/2025 at 2:34 P.M. Diagnoses included, but were not limited to anemia, diabetes, and cellulitis of the lower left leg. A Nurse's Progress Note dated 9/26/2025, indicated Resident H had been discharged home with their belongings along with discharge papers. There was no physician order to discharge Resident H to their home. A Transfer of Care/Discharge summary, dated [DATE], located in the Clinical Discharge and Narrative section of the electronic record was incomplete. There were blank sections for the following areas: transportation; customary routine; continence; cognitive patterns; dental; communication; nutritional status, vision; pressure ulcer/injury; mood and behavior patterns; activity pursuits; psychosocial well-being; physical functioning and structural problems- mobility devices, self-care and mobility. Resident H's current medications were also not listed on the Discharge Summary and the summary lacked a signature from the resident and/or the resident's representative. During an interview, on 3/6/2025 at 9:56 A.M., the RDCS indicated there should have been a physician's order to discharge the resident home. (continued on next page)

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE	TITLE	(X6) DATE

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F 0622 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	During an interview, on 3/6/2025 at 1:47 P.M., the RDCS indicated the Clinical Discharge and Narrative sections should have been completed based off the information in the most recent Minimum Data Set Assessment (MDS) assessment and should not have been left blank. During an interview, on 3/6/2025 at 1:49 P.M., the RDCS indicated a copy of the physician orders report for medications, from the electronic medical record, should have been printed and attached to the discharge summary and a copy should have been sent home with the resident. 3. The record for Resident J was reviewed on 3/5/2025 at 2:38 P.M. Diagnoses included, but were not limited to diabetes, hypertension, obesity and congestive heart failure. Resident J's payer source was private pay as of 7/22/2024. A Physician's Order, dated 8/29/2025, indicated an order to discharge the resident home with three (3) days of medications. A Transfer of Care/Discharge summary, dated [DATE], located in the Clinical Discharge and Narrative section of the electronic record had the following areas left blank: transportation; customary routine; continence; cognitive patterns; dental; communication; nutritional status, vision; pressure ulcer/injury; mood and behavior patterns; activity pursuits; psychosocial well-being; physical functioning and structural problems- mobility devices, self-care and mobility. The care plan goals and the medications to be taken at home were also not documented. A Receipt for Returned Products from [Name of Pharmacy], dated 8/30/2024, indicated the following medications were returned to the pharmacy: 2 Levofloxacin (antibiotic), 73 metformin (anti diabetes), 35 Lisinopril (blood pressure), 22 acetaminophen (pain), 4 multivitamins, 4 aspirin, 5 carvedilol (heart), 4 furosemide (water retention) and 39 atorvastatin (cholesterol). The reason for the return of all the medications was documented as discharged . During an interview, on 3/6/2025 at 1:19 P.M., the RDCS indicated the medications for Resident J should have been sent home with him. A Quarterly Minimum Data Set (MDS) assessment for Resident J was completed, on 8/27/2024, 2 days prior to the discharge date of 8/29/2024. During an interview, on 3/6/2025 at 1:47 P.M., the RDCS indicated the Clinical Discharge and Narrative sections should have been completed based off the information in the most recent Minimum Data Set (MDS) Assessment and not left blank. During an interview, on 3/6/2025 at 1:49 P.M., the RDCS indicated a copy of the physician's orders report from the electronic medical record should have been printed and attached to the discharge summary. 4. The record for Resident K was reviewed on 3/5/2025 at 2:30 P.M. Diagnoses included, but were not limited to anxiety, hypertension, pancreatitis, and alcoholic cirrhosis of the liver. There was no physician's order to discharge Resident J on 10/20/2025. (continued on next page)

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F 0622 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	A Transition of Care/Discharge summary, dated [DATE], indicated Resident J had been discharged home. The Clinical Discharge and Narrative section lacked any documentation in the following areas: transportation; customary routine; continence; cognitive patterns; dental; communication; nutritional status, vision; pressure ulcer/injury; mood and behavior patterns; activity pursuits; psychosocial well-being; physical functioning and structural problems- mobility devices, self-care and mobility. There was also no home medications listed on the summary and the summary was not signed by Resident J and/or Resident J's representative. During an interview, on 3/6/2025 at 9:56 A.M., the RDCS indicated there should have been a physician's order to discharge Resident J home. During an interview, on 3/6/2025 at 1:47 P.M., the RDCS indicated the Clinical Discharge and Narrative sections should have been completed based off the information in the most recent Minimum Data Set Assessment (MDS) and not left blank. An admission MDS had been completed, on 10/1/2025, nineteen (19) days prior to his discharge. During an interview, on 3/6/2025 at 1:49 P.M., the RDCS indicated a copy of the physician's orders report from the electronic medical record, which would have included a list of medications, should have been printed and attached to the discharge summary. 5. A record review for Resident L was completed on 3/5/2025 at 1:33 P.M. Diagnoses included, but were not limited to Diabetes Type 2, staphylococcal arthritis to the right knee, rheumatoid arthritis and anemia. Resident L's Physician's orders included the following medications: atorvastatin 80 milligrams (mg) daily, duloxetine 20 mg daily, Flomax 0.4 mg daily, rifampin 300 mg twice daily, and pantoprazole 40 mg daily. Resident L's medical record did not include a Physician's Order to be discharged to the community. In addition, there was no physician's order regarding if medications could be sent with the resident when he was discharged . A Transition of Care/Discharge summary, dated [DATE], indicated Resident L had been discharged home. The summary did not include a discharge medication list and the clinical discharge/narrative was incomplete. During an interview on 3/6/2025 at 1:49 P.M., the Regional Director of Clinical Services (RDCS) indicated a Physician's [NAME] should have been written for Resident L to discharge home, and a copy of the physician orders report from the electronic medical record should have been printed and attached to the discharge summary. The RDCS indicated the section for clinical discharge and narrative should have been completed based off the information in the most recent Minimum Data Set Assessment (MDS) and not left blank. (continued on next page)

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F 0622 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	On 3/6/2025 at 9:22 A.M., the RDCS provided the policy titled, Discharging Planning, dated 3/2023, and indicated the policy in the one currently used by the facility. The policy included the following: . Appropriate IDT members will participate in formulating a comprehensive discharge plan . 6. A physician's order for discharge including related medications, equipment, treatments, and home health will be obtained as applicable . 8. The instructions will be reviewed and signed by the resident/representative in a manner they are able to understand; a copy of the instructions will be given to the resident/representative On 3/6/2025 at 1:15 P.M., the RDCS provided the policy titled, Discharging a Resident with Medications, with a revision date of 8/1/2024, and indicated the policy was the one currently used by the facility. The policy included the following: . 1. Facility nurse shall review the medication list with the prescriber to determine which medication orders will be continued upon discharge. 1.1 A reconciliation of all discharge orders against medications taken during the resident stay shall be completed per facility policy. 2. Resident's physician/prescriber shall provide an order indicating that the resident may take medications with them upon discharge On 3/6/2025 at 1:47 P.M., the RDCS provided the Transition of Care/Discharge Summary Guidelines, undated, and indicated the guidelines were the ones currently used by the facility. The guidelines indicated the following: .Clinical Discharge and Narrative- MDS ARD: select the most recent MDS (if no MDS available leave blank) .Discharge Medications- Please print out home discharge medication instructions from [name of charting program], using the Physician Orders Report, with the discharge date as the Start date and end 30 days later This citation relates to complaint IN00453560. 3.1-12(a)(3)