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	06/26/2025

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 0697 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide safe, appropriate pain management for a resident who requires such services. Based on interview and record review, the facility failed to ensure a resident was assessed, monitored and treated for pain, which resulted in the resident calling 911 and going to the hospital due to her pain, for 1 of 3 residents reviewed for pain management, (Resident B). Finding includes: On 6/23/25 at 9:14 A.M., Resident B's clinical record was reviewed. The resident was admitted to the facility for one day, following an eight day hospital admission from home. The resident diagnoses included, but were not limited to, left shoulder and left arm pain, multiple sclerosis, spastic hemiplegia to the right side, polyneuropathy, chronic pain, venous insufficiency, overactive bladder, and spinal enthesopathy of the cervical region. Review of the Resident B's hospital records indicated the resident had been admitted for complaints of left shoulder, neck and left arm pain. The physician's assessment following testing indicated the resident had . a less that 50% partial-thickness partial width articular surface tear of the supraspinatus and infraspinatus tendons (a significant injury to the rotator cuff where the tear extends halfway through the thickness of the tendon on the joint surface, and also fraying on the outer surface of the tendons, which are part of the rotator cuff) . The Hospital medication orders, dated 6/3/25, included but were not limited to acteaminophen-oxycodon 325 mg-7.5mgon e tablet by mouth, every 4 hours as needed for pain. The facility physician's admission orders, dated 6/11/25, included, but were not limited to the instruction to administer oxycodone acetaminophen 7.5-3.5 mg, 1 tablet by mouth , every 4 hours as needed for pain. Resident B's admission Observation assessment form, dated 6/11/25, indicated at the time of admission (approximately 12:32 P.M., per nursing progress notes), the resident reported that she had had a new onset of pain that was not a chronic condition. There were no further documentation of pain, pain assessments or treatments to address the residents pain on admission. Review of the resident's medication administration record (MAR) indicated the resident had not received any medications for pain relief on 6/11/25. (continued on next page)

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

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F 0697 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	A Nursing Progress Note, dated 6/11/25 at 11:05 P.M., indicated .Resident used her personal cell phone in room and called 911 stating she has increased left shoulder pain and wants relief. Resident insists that she return back to hospital and will not be returning back to our facility. Resident informed of risks of leaving AMA [against medical advice]. Resident states she id leaving anyway. AMA form printed and signed by resident. DNS [Director of Nursing Services] .notified. Resident left with EMT [Emergency Medical Technician] via stretcher . The emergency room (ER) documentation, dated 6/12/25 at 12:40 A.M., indicated Resident B told the ER physician that when the facility staff had cleaned her up, they had rolled her to her left side and she protested because it had hurt her arm badly. Consequently, she had signed herself out of the facility and was brought to the ER. The x-ray of the left shoulder, indicated there was no fracture and no acute findings. The resident was admitted to the local hospital for a recurring urinary tract infection and pain. During an interview, on 6/23/25 at 12:00 P.M., Certified Nursing Assistant (CNA) 3, indicated she and CNA 6 were in Resident B's room at about 9:00 P.M., to change and reposition the resident. She indicated they had rolled the resident to her side to clean her and the resident had complained of pain, so they rolled her back to her back and completed her care. During an interview, on 6/23/25 at 12:45 P.M., CNA 6 indicated she had helped CNA 3 with Resident B's evening care when they properly rolled the resident with a draw-sheet to clean her, the resident had screamed out in pain, so they had rolled her back to her back to continue care. During an interview on 6/23/25 at 1:26 P.M., the Administrator indicated the resident had complained of pain, but had not requested pain medication. The Administrator indicated the resident should have been assessed for pain and her pain should have been addressed through intervention and/or medication. During an interview, on 6/23/25 at 3:02 P.M., the Director of Nursing indicated Resident B should have been assessed for pain every shift for 72 hours following her admission, but was not. The Director of Nursing indicated the nurse on duty, Licence Practical Nurse (LPN) 7 should have assessed the resident for pain and offered pain medication when the resident had yelled out in pain, but had not. During an interview with LPN 7, she indicated she went to the resident's room after CNA 6 and CNA 7 completed her evening care, to administer evening medications, and the resident had been tearful. LPN 7 indicated the resident was in a lot of pain from positioning with evening care. LPN indicated she had not completed a pain assessment, nor had she offered the resident pain medication. Finally, LPN 7 indicated she did not know when the resident had last had pain medication. LPN 7 indicated if the resident had wanted pain medications, she should have asked for them. On 6/24/25 at 12:15 P.M., the Administrator provided a policy titled, Pain Management Policy, dated 7/24 and indicated it was the current pain management policy. The policy indicated, .Residents are assessed for pain upon admission, and during medication administration .Interview Resident-Pain medications will be prescribed and given based upon the intensity of pain .MILD =(1-2) MODERATE = (3-5) SEVERE = (6-8) VERY SEVERE, HORRIBLE = (9-10) .Pain [using faces indicated tears = 10 worst pain] . This citation relates to Complaints IN00461459 and IN00461410. (continued on next page)

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F 0697 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	3.1-37(a)