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	06/26/2026

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 0684 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide appropriate treatment and care according to orders, resident?s preferences and goals. Based on observations, interviews, and record reviews, the facility failed to assess skin related to a blackened toe for 1 of 3 residents (Resident G) and failed to sign for medications immediately after administration for 2 of 3 residents reviewed for changes in condition. (Residents E and F) Findings include: 1. A records review was completed on 6/25/2026 at 9:33 A.M. for Resident G. Diagnoses included, but were not limited to, hemiplegia/hemiparesis following cerebral infarction left non-dominant side, chronic kidney disease stage 3, unspecified chronic obstructive reflux uropathy, unspecified severe protein calorie malnutrition, and adult failure to thrive. A Quarterly Minimum Data Set (MDS) assessment, dated 4/21/2026, indicated the resident exhibited a moderate cognitive deficit, had not exhibited behaviors of refusal of care, had impaired range of motion on his upper and lower extremities on one side, was dependent on staff for transfer needs, required moderate assistance for eating and had an indwelling urinary catheter and a colostomy. A current Care Plan, initiated on 8/11/2022 indicated Resident was at risk for skin breakdown due to the following: rare moist skin, chair fast, slightly limited ability to change or control body position, probable inadequate nutrition, requires assist with mobility, potential problem for friction and shear. In addition, Resident G had a history of an abrasion on his left 2nd toe and skin impairment on the left tip of the great toe. Interventions included, but were not limited to: Assess and document skin condition weekly and as needed. Notify physician of abnormal findings. A history and physical assessment, completed on 6/10/2026 for Resident G did not indicated the resident had any skin or integumentary system issues. Review of wound management notes indicated the resident had no wounds between 1/1/2026 and 6/23/2026. Review of the most recent weekly skin and vital sign assessment, dated 6/16/2023, indicated there were no skin issues. Shower documents, dated 6/22/2026 at 2:45 P.M., indicated Resident G had a bed bath with no concerns noted to skin Review of a transfer form dated 6/23/2026 for Resident G upon his transfer to an acute care facility indicated his skin condition was intact cool clammy. Resident G was transferred to a local acute care facility on 6/23/2026 at 11:45 A.M. (continued on next page)

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

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F 0684 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	An emergency room note, entered by an RN at the local acute care facility, on 6/24/2026 at 9:15 A.M. indicated Resident G's left great toe was oozing pus from the nail bed and his left third toe had a large black callous that was removed at the acute care center. The resident was referred to the acute care wound care specialist and photos of Resident G's wounds were sent on 6/24/2026 at 2:05 P.M. A wound care assessment, dated 6/24/2026, from the acute care hospital indicated Resident G's left 3rd toe had a black callous that was removed without incident revealing clean, new skin growth that was pink underneath the callous. In addition, the left great toe's nail bed was peeling off and there was purulent drainage coming out from underneath the nail. The great toe was covered with a moisture-wicking gauze, and a podiatry consult was recommended for removal of the nail. On 6/26/2026 at 1:31 P.M. a current policy, dated 5/2022 and titled, Skin Management Program was provided by the ED. The policy indicated, .Any skin alterations noted by direct caregivers during daily care and/or shower days must be reported to the licensed nurse for further assessment. 2. A record review was completed on 6/26/2026 at 9:22 A.M. for Resident E. Diagnoses included, but were not limited to, hydronephrosis with ureteral calculous obstruction (swelling of the kidney caused by urine back up due to obstruction by stones), bipolar disorder, and acute respiratory failure with hypoxia (the inability of the lungs to get enough oxygen into the bloodstream. A Discharge Minimum Data Set assessment, dated 6/4/2026, indicated Resident E was cognitively intact, had no issues with rejection of care and received an antipsychotic, antidepressant, and an opioid medication. The Care Plan did not indicate any issue with Resident E refusing medications. The May 2025 Medication Administration Record for Resident E indicated 3 instances of medications that had been given but was charted late on 5/12, 5/16, and 5/18/2026. During an interview on 6/26/2026 at 8:45 A.M., LPN 2 indicated she sometimes documented medication administration late but knew she should have documented the medication administration immediately after the medication had been administered. She indicated she was usually able to get medications passed in the allowable timeframe. 3. A record review was completed on 6/26/2026 at 10:00 A.M. for Resident F. Diagnoses included, but were not limited to, hemiplegia and hemiparesis following cerebral infarction affecting left non-dominant side, neuralgia and neuritis, and major depressive disorder. A Quarterly Minimum Data Set assessment, dated 4/29/2026, indicated Resident F had a moderate cognitive deficit, had no issues with refusal of care and received antidepressant and anticoagulant medications. Review of the May Medication Administration Record (MAR) indicated medications had been documented as administered late on two occasions. (continued on next page)

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F 0684 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	4. A record review was completed on 6/26/2026 at 10:27 A.M. for Resident G. Diagnoses included, but were not limited to, congestive heart failure, malignant neoplasm of retroperitoneum and peritoneum, and chronic kidney disease. A Quarterly Minimum Data Set assessment, dated 5/28/2026, indicated Resident G had a moderate cognitive deficit. She had no issues with refusal of care and received antipsychotic and antidepressant medications. The June Medication Administration Record (MAR) indicated medications were documented as having been administered late nearly every day. During an interview on 6/26/2026 at 12:55 A.M., Resident G indicated sometimes her medications were late, but she was unable to recall how often it happened or when it had last happened. During an observation of medication administration on 6/26/2026 at 8:54 A.M. there were no concerns. LPN 2 signed for medications immediately after administering them. However, during an interview on 6/26/2026 at 1:06 P.M. with LPN 3 she refused to answer questions regarding administering medications timely and not signing out the medications as given timely. During an interview on 6/26/2026 at 1:21 P.M., the Regional Director of Clinical Services indicated medications should have been signed for directly after they were administered. On 6/26/2026 at 1:30 P.M. a current Procedure, dated 4/2025 and titled, Medication Administration (Medication Pass Procedure) was provided by the ED. The procedure indicated, .Medication administration will be recorded on the EMAR (Electronic Medication Administration Record) after given On 6/26/2026 at 1:31 P.M. a current policy, dated 5/2022 and titled, Skin Management Program was provided by the ED. The policy indicated, .Any skin alterations noted by direct caregivers during daily care and/or shower days must be reported to the licensed nurse for further assessment. This citation relates to Intakes 3026355 and 3053196 410 IAC (Indiana Administrative Code) 3.1-37