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	02/24/2026

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 0580 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Immediately tell the resident, the resident's doctor, and a family member of situations (injury/decline/room, etc.) that affect the resident. Based on record review and interview, the facility failed to follow a physician's order to notify the provider of a 3 pound weight gain in 1 day for 1 of 3 residents reviewed for edema. (Resident 33) Finding includes: A record review for Resident 33 was completed on 2/19/2026 at 12:52 P.M. Diagnoses included, but were not limited to, chronic congestive heart failure (CHF). A Quarterly Minimum Data Set (MDS) assessment, dated 1/12/2026, indicated Resident 33 received a diuretic daily for CHF. A Physician's Order, dated 1/14/2026, indicated Resident 33 was to be weighed daily and the physician was to be called for a gain of 3 pounds in one day or 5 pounds in one week. On 2/8/2026 the Medication Administration Record (MAR) indicated the resident's weight was 197 pounds and on 2/9/2026 it was 200.1 pounds, a gain of 3.1 pounds in one day. The MAR indicated the physician was not notified of the 3.1 pound gain. During an interview on 2/24/2026 at 10:09 A.M. the DON indicated the physician should have been notified of the weight gain. She further indicated the facility did not have a policy regarding following physician orders as they followed the standards of practice. 3.1-37(a)

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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F 0585 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Honor the resident's right to voice grievances without discrimination or reprisal and the facility must establish a grievance policy and make prompt efforts to resolve grievances. Based on observation and interview, the facility failed to readily provide grievance forms for residents to place an anonymous grievance for 65 of 65 residents.Finding includes:During a Resident Council meeting, on 2/19/2026 at 2:30 P.M., 12 of 12 residents in attendance indicated grievance forms were located behind the nursing station and they had to ask a staff member for a grievance form if they wanted to file a grievance. The residents indicated they were unable to file a grievance anonymously.During an observation and interview, on 2/19/2026 at 3:13 P.M., the Executive Director indicated grievance forms were located behind the nurse's station, but were not available for residents to obtain anonymously without asking for staff assistance. The Executive Director looked at one of the nurse's stations and there were no forms available in the plastic wall hanger behind the nurse's station. The Executive Director indicated the residents needed to ask for a grievance form.A policy was provided, on 2/24/2026 at 9:45 A.M., by the Executive Director. The policy titled, Resident Concerns and Grievances, indicated, .Resident, representative or family concerns/grievances occurring during the resident's stay shall be responded to promptly and without fear of reprisal or discrimination. Each resident has the right to: file grievances orally or in writing; file a grievance anonymously, and to obtain a written decision regarding his or her grievance. Grievances can be submitted anonymously as preferred by a resident, representative and/or family member. Anonymity will be maintained by the Grievance Official throughout the resolution process.

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F 0676 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure residents do not lose the ability to perform activities of daily living unless there is a medical reason. Based on observation, interview and record review, the facility failed to ensure showers were provided for 1 of 6 residents reviewed for ADL (Activities of Daily Living) care. (Resident 21)Finding includes:On 2/18/2026, at 2:39 P.M., Resident 21 was observed in the Memory Care unit dayroom with greasy, unkempt hair. On 2/20/2026, at 11:30 A.M., Resident 21 was observed in the dayroom of the Memory Care unit with her hair still unkempt and greasy.On 2/23/2026 at 10:06 A.M. Resident 21 was observed in the Memory Care unit while exiting her room; her hair appeared disheveled and greasy.The clinical record of Resident 21 was reviewed on 2/19/2026 at 12:54 P.M. The resident's diagnoses included, but were not limited to: Alzheimer's disease, a displaced fracture of the base of the neck of the left femur, paranoid schizophrenia, diabetes mellitus, osteoporosis, personal history of intraductal carcinoma in situ of the left breast, anemia, severe protein-calorie malnutrition, retention of urine, cognitive or emotional deficit following cerebral infarction, depression, dysphagia, anorexia, vascular dementia and acquired absence of both breasts and nipples.A Quarterly Minimum Data Set (MDS) assessment, dated 2/10/2026, indicated the resident had both short-term and long-term memory problems and moderately impaired cognitive skills for daily decision making and required partial assistance with bathing and/or showering.A current Care Plan, revised on 2/11/2026, indicated Resident 21 had a problem of refusing showers and interventions included but were not limited to: explain tasks in detail and allow resident time to process, staff will continue to encourage resident to allow care as resident tolerates. Resident 21's current Care Plan included a problem of needing assistance with ADLs. Interventions included but were not limited to: assist with bathing as needed per resident preference, offer showers two times per week and resident prefers two showers in the morning or early afternoon weekly.Documentation from the Electronic Medical Record (EMR) and shower sheets (written documentation of a resident's hygiene care) were both reviewed for 1/20/2026 through 2/20/2026. Resident 21 had a shower on 1/21/2026; there was only one attempt documented to shower the resident on 1/28/2026 and the resident refused. There were no further attempts documented to shower the resident. Resident 21 received a shower on 1/31/2026. There was only one attempt to shower the resident documented on 2/7/2026 and Resident 21 refused, there were no further attempts documented to shower the resident. There were 3 documented attempts to aide Resident 21 to shower on 2/11/2026. Resident 21 received a shower on 2/14/2026 and there were 3 documented attempts to shower the resident on 2/18/2026 and the resident refused the shower all 3 times.The nursing notes failed to evidence any documentation of the resident's refusal to shower between 1/20/2026 through 2/20/2026. During an interview, on 2/20/2026 at 1:30 P.M., QMA 7 indicated showers were completed according to the Memory Care unit schedule, which was found in the shower book. The QMA indicated the aide should have completed a shower sheet for each resident shower they completed. The QMA indicated a resident shower included a hair shampoo, bilateral fingernail care and a facial shave. QMA 7 indicated if a resident had refused their shower, the aide would have re-approached and tried to get the resident to shower later. The QMA indicated the aide would have attempted to help the resident shower 3 times. QMA 7 indicated if the resident refused 3 times, the aide would have notified the nurse and the nurse would have documented the resident's refusal. During an interview, on 2/20/2026 at 2:20 P.M., the Unit Manager indicated a resident should have been offered a shower at least 3 times and then the aide should have notified the nurse. The Unit Manager indicated the nurse should have documented the resident's refusal in the Electronic Medical Record (EMR).There was no explanation given as to why Resident 21 had only been offered and/or showered once in the week of 1/20/2026 and once for the week of 2/1/2026. In addition, it was unclear why there were no nursing notes regarding the resident's (continued on next page)

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F 0676 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	repeated refusals to shower. During an interview, on 2/23/2026 at 11:26 A.M., the Regional Director of Clinical Services (RDCS) indicated the facility did not have a policy for providing ADLs, including showers and/or baths.3.1 - 38(a)(1)

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F 0740 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure each resident must receive and the facility must provide necessary behavioral health care and services. Based on observation, record review and interview, the facility failed to provide behavioral interventions for 1 of 2 residents reviewed for behavioral-emotional issues. (Resident 19) Finding includes:During an observation, on 2/18/2026 at 10:22 A.M., Resident 19 had a very strong odor of urine in her room.During an observation, on 2/18/2026 at 11:43 A.M., Resident 19 was observed to be hoarding paper towels from the dispenser in the dining room. Resident 19 was pulling paper towels, folding them and placing them under her arm. The stack was approximately three inches thick. Staff observing the behavior had not intervened with this behavior.During an observation, on 2/18/2026 at 1:32 P.M., Resident 19 was observed in dining room with a very strong smell of urine.During an observation, on 2/18/2026 at 3:26 P.M., Resident 19 was sitting in the dining room, and a strong scent of urine could be smelled.During an observation, on 2/19/2026 at 12:49 P.M., Resident 19's room had a strong smell of urine.During an observation, on 2/18/2026 at 12:11 P.M., Resident 19 was observed wearing ill-fitting clothing that were too big with her pants dragging on the ground, drooping off of her buttock to her mid-thigh and a shirt two sizes too big.During an observation, on 2/19/2026 at 11:56 A.M., Resident 19 was observed to be wearing the same clothing from 2/18/2026.During an observation, on 2/20/2026 at 8:32 A.M., Resident 19 was observed to be wearing the same clothing from 2/18/2026.During an observation, on 2/23/2026 at 11:54 A.M., Resident 19 was observed to be wearing the same clothing from 2/18/2026. The shirt had many visible stains. A very strong sent of urine could be smelled from six feet away from the resident.A record review for Resident 19 was completed on 2/23/2026 at 12:59 P.M. Diagnoses included, but were not limited to: Alzheimer's disease, dementia, generalized anxiety and schizophrenia.A Quarterly Minimum Data Set (MDS) assessment, dated 2/20/2026, indicated Resident 19 had moderate cognitive impairment, had no documented behaviors during the 7-day look back period, required partial/moderate assistance with toileting before hygiene and showering, required supervision for personal hygiene and dressing and was occasionally incontinent of bladder.A Nurse Practitioner Progress Note, on 2/2/2026 at 5:12 P.M., indicated Resident 19 was co-managed with psychiatry and currently not taking any medications for her schizophrenia. The note indicated Resident 19 received supportive care only due to non-compliance related to unspecified psychosis.Resident 19 had care plans that addressed not adjusting well to changes, hitting herself while talking to an imaginary person or sitting without talking, refusing shower and facial hair trimming, rummaging through roommates belongings and taking items, refusing nursing assessments, refusing to wear incontinent briefs and using textured bath towels in place of traditional incontinent briefs, carrying around plastic bags with personal belongings, displaying verbal and combative agitation towards staff and thumping another resident after being provoked, However, there were no personalized interventions to prevent behavioral issues.A Care Plan, initiated on 9/5/2017 and updated on 4/2/2025, indicated Resident 19 required assistance with ADLs (activities of daily living) including toilet use. Resident 19 often refuses ADL care/assistance and could become combative during care at times. Interventions included, but were not limited to: offer toilet upon rising, before or after meals, prior to bed and as needed throughout the night, encourage Resident 19 to make choices in care such as clothing, shower time preference, etc., Resident 19 prefers to wash herself and not shower, and encourage resident to do as much for self as possible and praise efforts for self-care. However, there were no personalized interventions to prevent behavioral issues.During an interview, on 2/23/2026 at 8:22 P.M., Resident 19's guardian indicated Resident 19's hygiene was atrocious as she would not use the toilet, but would stack towels under herself and urinate on the towels. She indicated the facility had let these behaviors happen and was not doing anything for Resident 19 or her situation. She (continued on next page)

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F 0740 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	indicated the facility did not talk about her behavioral health, nor had the psychiatric nurse practitioner spoken to her about Resident 19's behavioral issues. She indicated she had been told Resident 19 would not take any medication, so there was nothing they could do for her regarding her behaviors and lack of hygiene.During an interview and observation, on 2/24/2026 at 11:57 A.M., the floating Social Service director (SSD) indicated the psychiatric nurse practitioner checked on Resident 19 to ensure she was not having any increased behaviors and was doing well. She indicated any observed behaviors should have been documented in the nursing progress notes. She indicated Resident 19 refused weekly assessments, vital signs and skin assessments and only had had one recent nursing progress note of refusing a shower. She indicated refusing to change clothing and showering should have been charted as a behavior. The SSD went to the room of Resident 19 and indicated the room smelled badly of urine. She indicated after leaving the room, This makes me want to cry, and the SSD became tearful.During an interview, on 2/24/2026 at 12:24 P.M., LPN 3 indicated staff attempted to offer services to Resident 19 by talking and by different staff approaching her at different times. She indicated staff had to be careful not to upset Resident 19.During an interview, on 2/24/2026 at 12:30 P.M., LPN 2 indicated the clothing Resident 19 had been wearing was the only clothing she would wear. She indicated resident interventions on the care plan were not specific to her care as Resident 19 was in her own world with delusions She indicated staff approached Resident 19 with different staff and times to offer services.During an interview, on 2/24/2026 at 12:49 P.M., the facility psychiatric nurse practitioner indicated she had not been advised of any complaints about behaviors that would need medicated. She indicated staff had not advised her of any refusals of care or documented any behaviors. She indicated the staff should have been trialing different times and ways to approach Resident 19 regarding care and showering to have a positive response.During an interview, on 2/24/2026 at 12:40 P.M., the Executive Director indicated Resident 19 had rights and the facility staff had asked her to change her clothing, but she had refused. He indicated Resident 19 was content, happy and at her baseline.A policy was requested for a behavioral health program, on 2/24/2026 at 1:33 P.M. A policy was not provided by the facility prior to the survey exit.3.1-43(a)(1)

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F 0757 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure each resident’s drug regimen must be free from unnecessary drugs. Based on interview and record review, the facility failed to ensure required blood monitoring was completed timely for 1 of 5 residents reviewed for unnecessary medications. (Resident 29)Finding includes: The clinical record for Resident 29 was reviewed on 2/19/2026 at 2:00 P.M. The resident's diagnoses included, but were not limited to: dementia, psychosis, anxiety, anemia, atherosclerotic heart disease, severe protein-calorie malnutrition, spondylosis, hypertension, dysphagia, hydronephrosis, hypotension, obstructive and reflux uropathy and atrophy of the kidney.A Quarterly Minimum Data Set (MDS) assessment, dated 1/19/2026, indicated the resident received antianxiety, antidepressant, anticonvulsant and hypnotic medications.A current Care Plan, initiated 11/14/2025, indicated Resident 29 was at risk for adverse side effects related to use of anticonvulsant or antiseizure medication and interventions included but were not limited to: labs as ordered.Current Physician's orders included Divalproex (a prescription medication used to treat epilepsy (seizures), manic episodes associated with bipolar disorder, and to prevent migraine headaches) capsule, delayed-release sprinkles; 125 milligrams (mg), give 2 capsules twice a day. This order was initiated on 11/14/2025.The November 2025 Medication Administration Record (MAR) indicated Resident 29 began receiving the Divalproex (Brand name of Depakote) on 11/15/2025. The December 2025 MAR, January 2026 MAR and February 2026 MAR indicated Resident 29 had received Divalproex from 11/15/2025 through 2/23/2026.A Physician's Order, dated 11/13/2025, indicated Resident 29 was to have a one-time blood draw for an Ammonia and Valproic Acid (Depakote is specifically formulated to be gentler on the stomach, often causing fewer GI side effects than valproic acid) levels. This order was discontinued on 11/25/2025 without having been completed. During an interview, on 2/23/2026 at 2:05 P.M., the Director of Nursing (DON) indicated the Valproic level was intended to have been drawn for Resident 29 and indicated she could not locate the lab results in the chart.During an interview, on 2/23/2026 at 3:00 P.M., the DON indicated the lab was discontinued on 11/28/2025 after being ordered on 11/15/2025. During an interview, on 2/24/2026 at 9:45 A.M., the Regional Director of Clinical Services (RDCS) indicated the Resident 29 had not had any Valproic or Ammonia levels monitored at all. A new Physician's Order, dated 2/23/2026, indicated for Resident 29 was to have an Ammonia and Valproic acid level drawn the next lab day and then drawn every 6 months.On 3/23/2026 at 3:00 P.M., the DON provided a policy titled, Guidelines for Lab and Radiology Tracking, dated 4/2024 and indicated the policy was the one currently used by the facility. The policy indicated .Confirm that each lab.due has been obtained.If any lab.ordered are not resulted as expected, investigate and take the necessary steps to obtain results.3.1 - 25 (h)3.1 - 25 (j)

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F 0812 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Procure food from sources approved or considered satisfactory and store, prepare, distribute and serve food in accordance with professional standards. Based on observation, interview and record review, the facility failed to prepare, store and serve food in a sanitary manner in 1 of 1 kitchen and 1 of 2 dining halls. (Main Dining Hall) This had the potential to affect 62 of 64 residents who receive meals from the kitchen and 18 of 18 residents who ate in the Main Dining Hall. Findings include:1 An initial tour of the kitchen with the Dietary Manager (DM) was completed on 2/18/2026 at 9:39 A.M. During the tour, the following was observed:-A two door upright freezer had a thick black substance on the rubber seal and the stainless steel portion where the seal met the stainless steel. -The walk-in cooler had a container of concentrated beef broth base with a best by date of 12/2025.-The freezer had four unlabeled house made shakes without a date indicating when the shakes had been made or needed to be used by or discarded.- A large area of a dark brown substance was observed on the side of the stovetop and the side of the oven.During an interview on 2/18/2026 at 9:54 A.M., the DM indicated the thick black substance was mildew. He threw out the beef concentrate and indicated it should have been disposed of in January. He indicated the label for the shakes must have fallen off in the freezer and indicated they should have been labeled and dated. He indicated he had a company coming to clean the kitchen equipment and the brown build-up was grease. During an interview on 2/18/2026 at 2:38 P.M., the DM indicated he had scrubbed the freezer seals, but continued scrubbing would cause the seals to rip, so new ones were ordered on 2/18/2026. 2. During the lunch meal observation in the Main Dining Hall on 2/18/2026 at 12:03 P.M. until 12:12 P.M., the following was observed:-CNA 6 cupped her hand over the plastic cup of water, touching the rim of the drinking area of the cup with her fingers, and served the cup to a resident. CNA 6 also placed her fingers on the drinking area of a coffee cup and served the coffee to the same resident. -CNA 6 put her fingers inside a resident's coffee cup before pouring the coffee into the cup and serving the resident. -CNA 6 placed her hands on rim of a cup of water while serving the cup to a resident. During an interview on 2/24/2026 at 1:21 P., the DM indicated the correct way to serve a resident a drink was to always hold the bottom of the cup, keeping fingers away from the drinking surface of the cup. On 2/24/2026 at 9:45 AM, the Executive Director (ED) provided a policy dated 5/2025, and titled, Food Storage, and identified the policy as the one currently used by the facility. The policy indicated, .8. Refrigerated, ready-to-eat, potentially hazardous food purchased from approved vendors shall be clearly marked with the date the original container is opened and the date by which the food shall be consumed or discarded. This opened food can be held at 41 degrees Fahrenheit or less for no more than 7 days and the date marked may not exceed the manufacturer's use-by date .12 .c. Foods should be covered or wrapped tightly, labeled and dated with the date the item is being placed in the freezer On 2/24/2026 at 9:45 AM, the ED provided a policy dated 6/2025, and titled, Kitchen Cleanliness, and identified the policy as the one currently used by the facility. The policy indicated, .A clean, sanitary, and safe kitchen environment will be maintained at all times to ensure the health and well-being of our residents, staff, and visitors. All kitchen areas, including food preparation surfaces, equipment, storage areas, walls, and floors must be cleaned regularly and kept free of debris, spills, and potential contaminants On 2/24/2026 at 9:45 AM, the ED provided a policy dated 5/2024, and titled, Meal Service and Distribution, and identified the policy as the one currently used by the facility. The policy indicated, .6. Utensils, cups, glasses and dishes will be handled in such a way as to avoid touching any food contact surface .3.1-(i)(l)(3)