STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	105432	A. Building B. Wing	06/11/2026

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Riverside Care Center	899 NW 4th Street Miami, FL 33128

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 0550 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Honor the resident's right to a dignified existence, self-determination, communication, and to exercise his or her rights. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, record review and interview the facility failed to ensure Resident #92 was cared for with dignity and respect as evidenced by Resident#92 was observed in the hallway next to the shower room on a shower chair with the left posterior and anterior upper extremity exposed. There were 116 residents residing in the facility at the time of the survey. The findings included:Observation on 06/08/2026 at 9:05 AM Resident #92 was sitting in the hallway, unattended, wearing a gown, next to the shower room on a shower chair with the left posterior and anterior upper extremity exposed. Staff E, Certified Nursing Assistant (CNA), revealed Resident #92 is waiting her turn to use the shower room. On 06/09/2026 at 9:51 AM, Staff C, CNA, interviewed via Spanish Translator revealed residents that are showered in the shower room waited in front of the shower room with their assigned CNAs, fully covered in their gowns and a clean sheet for privacy. Review of the medical records for Resident # 92 revealed the resident was admitted to the facility on [DATE]. Clinical diagnoses included but not limited to: Hypertensive Heart Disease without Heart Failure. Record review of Resident #92's admission Minimum Data Set (MDS) dated [DATE] revealed: Section C for Cognitive Patterns documented Brief Interview for Mental Status Score (BIMS) 06 on a 0-15 scale indicating the resident is cognitively impaired. Section GG for Functional Abilities documented dependent for care. Review of the facility policy and procedure titled Dignity/Privacy revision date 01/2026 states: Each resident shall be cared for in a manner that promotes and enhances his or her sense of well-being, level of satisfaction with life, and feelings of self-worth and self-esteem. Residents are treated with dignity and respect at all times.

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 0583 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Keep residents' personal and medical records private and confidential. Based on observation, record review and interviews, the facility failed to protect privacy and confidentiality of resident's medical records as evidenced by one observation of a computer in the 2nd floor new wing hallway being left open and unattended with a resident's information visible. Photo evidence taken. There were 116 resident's residing in the facility at the time of survey. The findings include:Observation on 06/09/2026 at 8:59 AM revealed an Electronic Health Record (EHR) was left open and unattended with a resident's visible information on the 2nd floor new wing computer in hallway. Photo evidence provided. Interview on 06/09/2026 at 10:04 AM the Assistant Director of Nursing (ADON) stated: The computers that are located on the walls in the hallways are used by the Certified Nursing Assistants (CNAs) to chart and document on their residents. The CNAs are also educated to not leave them open with resident information visible.Interview on 06/10/2026 at 2:49 PM; the Director of Nursing (DON) stated: CNAs receive frequent education on resident privacy, especially since many of the staff are new. HIPAA is covered during new employee orientation, and additional education is provided as needed. Staff are reminded that resident information should not be discussed in public areas or in front of other residents, visitors, or unauthorized individuals. The hallway computers are available for CNAs to use for documentation in the electronic health record. Staff are expected to log off the system before leaving a computer unattended to protect resident confidentiality and maintain Health Insurance Portability and Accountability Act (HIPAA) compliance. Ongoing education and monitoring help reinforce these privacy and security practices.Review of the facility's policy titled Confidentiality of Information and Personal Privacy 01/2026 stated Policy Statement - Our facility will protect and safeguard resident confidentiality and personal privacy. Policy Interpretation and Implementation1. The facility will safeguard the personal privacy and confidentiality of all resident personal and medical records.4. Access to resident personal and medical records will be limited to authorized staff and business associates.

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F 0689 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure that a nursing home area is free from accident hazards and provides adequate supervision to prevent accidents. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation records reviewed and interviews, the facility's failed to ensure a safe environment free of potential accidents and hazards for one out of four sampled residents, as evidenced by during observation two knives were observed in Resident # 88's room in a plastic container on the overbed table. One razor was observed on the sink in an open unattended shower room on the second-floor unit. There were 116 residents residing in the facility at the time of the survey. The findings included: During observation on 06/08/2026 at 8:53 AM Two knives were observed on the overbed table stored in plastic container in Resident #88's room. On 06/09/2026 at 9:38 AM Resident #88 was in bed awake, no distress noted and refused to be interviewed by the surveyor. On 06/10/2026 at 9:29 AM Resident #88 in the hallway sitting on a rolling walker, no distress noted. 06/10/2026 at 8:35 AM the surveyor showed the Director of Nursing (DON) photo evidence of the knives observed in a resident room and the DON acknowledged the findings. Observation on 06/11/2026 at 10:00 AM in the open and unattended shower room on the second-floor unit a razor was noted on the sink in the shower room. The Facility Staff were notified by the surveyor to remove the razor. On 06/11/2026 at 10:52, the surveyor showed the Director of Nursing (DON) photo evidence of findings (razor in the open unattended shower room) and the DON acknowledged findings.Review of the medical records for Resident #88 revealed the resident was admitted to the facility on [DATE]. Clinical diagnoses included but not limited to: Type Two (2) Diabetes Mellitus with Diabetic Neuropathy.Review of the Physician's Orders Sheet for June 2026 revealed Resident #88 had orders that included but not limited to: Physician certified this resident to require Nursing Care at level of care: Skilled.Record review of Resident # 88's Quarterly Minimum Data Set (MDS) dated [DATE] revealed: Section C for Cognitive Patterns documented Brief Interview for Mental Status Score (BIMS) 13 on a 0-15 scale indicating the resident is cognitively intact. Section E for Behaviors documented no behaviors exhibited. Section GG for Functional Abilities documented no impairment of upper and lower extremities, uses walker and wheelchair, independent for care. Section N for Medications documented resident is taking Diuretic, Opioid, Hypoglycemic, Anticonvulsant.Record review of Resident # 88's Care Plans Dated 06/07/2026 revealed: The resident has Activities of daily living (ADL) self-care performance deficit related to multiple medical conditions, muscle weakness, balance deficits, Alzheimer's, Major depression. Resident able to ambulate with a four wheeled walker. Interventions include Ambulation program with rollator three to five times weekly. Maintenance Range of Motion to all extremities during daily care by staff. On 06/09/2026 at 9:48 AM) in an interview via Spanish Translator Staff A, Licensed Practical Nurse (LPN), revealed that during rounds if any items are found that the residents are not allowed to have, the resident and the family are educated. For example, residents are not allowed to have knives stored in their rooms, it is a safety issue. Interview on 06/09/2026 at 9:57 AM Staff D, Certified Nursing assistant stated via Spanish Translator that during rounds the residents are checked on to make sure they are safe, positioned properly and provide needed care. If specifically, a knife or sharp object was found in the residents' room, the object would be removed and the nurse informed because that is a safety issue for the residents. During an interview on 06/11/2026 at 10:52 AM, the DON stated that the procedure after residents are showered in the shower rooms- staff must ensure that the shower rooms are cleaned and free of any personal hygiene items. Razors cannot be stored in the shower room; it is a safety issue for the residents and staff. Review of the facility policy and procedure titled Hazardous Areas, Devices and Equipment revision date 01/2026 states: All hazardous areas, devices and equipment in the facility will be identified and addressed appropriately to ensure resident safety and mitigate accident hazards to the extent possible. Policy Interpretation and Implementation:As part of the facility's overall safety and accident prevention program, hazardous areas and objects in the resident environment will be identified and addressed by the (continued on next page)

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F 0689 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	safety committee.Identification of Hazards1. A Hazard is defined as anything in the environment that has the potential to cause injury or illness.Examples of environmental hazards include, but are not limited to the following:3. Sharp objects that are accessible to vulnerable residents