STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	106043	A. Building B. Wing	03/05/2026

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Riverchase Health and Rehabilitation Center	1017 Strong Rd Quincy, FL 32351

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 0600 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Protect each resident from all types of abuse such as physical, mental, sexual abuse, physical punishment, and neglect by anybody. Based on interviews and record review, the facility failed to protect 1 of 3 residents reviewed for neglect when staff failed to recognize, assess, and appropriately respond to injuries after the resident sustained a fall. (Resident #1)The findings include:Review of Resident #1's medical record revealed that on February 15, 2026, at 2:50 PM, Staff A, Licensed Practical Nurse (LPN), documented that Resident #1 fell during incontinence care and was found with abrasions, bruising, and redness to the right side and left upper back, a mark on the left forehead, and discoloration to the right knee, right arm, and right elbow.Review of Resident #1's medication orders revealed she was prescribed two daily anticoagulants: Clopidogrel and Aspirin. Documentation reflected that Resident #1 received Clopidogrel at bedtime on February 14, 2026, and Aspirin on the morning of February 15, 2026. The orders also directed staff to monitor for potential anticoagulant side effects and to notify the physician if the resident exhibited any of the following: sudden severe headache, nausea, vomiting, bruising, sudden changes in mental status, or shortness of breath.During an interview conducted on March 4, 2026, at approximately 4:00 PM, Resident #1's daughter reported that Staff A contacted her immediately after the fall on February 15. 2026. She further stated this phone call prompted her to report to the facility. She stated that she took photographs of the red marks on Resident #1's head and back and noticed she was in a lot of pain. Resident #1's daughter noted that she was acting different by talking louder than usual and stated that she is usually soft spoken and quiet. Resident #1's daughter shared her concerns about the injuries with Staff A. According to the daughter, Staff A assured her that the physician had been notified of the fall and that an Xˆray had been ordered and Tylenol was being administered for her complaint of pain. The daughter stated she assisted Resident #1 in eating dinner, and she left the facility while Resident #1 was sleeping at approximately 5:00 PM. About an hour later, she received a call informing her that Resident #1 was being transferred to the hospital. When she arrived at the hospital, the hospital staff informed her that Resident #1 had passed away.An interview conducted with the facility's Nurse Practitioner on March 5, 2026, at 10:11 AM revealed that Staff A had informed him that Residentˆ#1 had fallen from the bed and was reporting pain in both legs. He recalled giving a verbal order for an Xˆray. He stated he was not made aware of the visible injuries and explained that, had he known the full extent of those injuries, he would have sent Resident #1 to the emergency room for further evaluation.A review of Resident #1's Changeˆinˆ Condition Note documented on February 15, 2026, at 7:47 PM showed that Staff B, LPN, had documented that Resident #1 was nauseated, vomiting, experiencing shortness of breath, and became unresponsive. Resident #1 was transferred to the local hospital at 9:15 PM. At 1:00 AM on February 16, 2026, it was documented that Resident #1's daughter notified the facility that Resident #1 had passed away. A review of Resident #1's Progress Notes revealed that Emergency Medical Services were called and arrived on February 15, 2026 at approximately 9:15 PM to transport Resident #1 to the local hospital after Resident #1 was found unresponsive and in respiratory distress. Documentation reflected that the first notation of a possible head injury occurred on February 15, 2026 at 2:50 PM. Review of the facility's Abuse and Neglect policy revealed that Neglect was defined as failure of the facility, its employees, or service providers to provide goods and services to a resident that are necessary to avoid physical harm, pain, mental anguish, or emotional distress.

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