STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 106094	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 01/28/2026

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Riviera Health Resort	6901 Yumuri Street Coral Gables, FL 33156

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 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, interview and record review, the facility failed to ensure the safety of one (Resident #7) out of three vulnerable residents reviewed for falls. As evidenced by during transport from the facility Resident #7 fell to the floor of the transport vehicle in his wheelchair and sustained a rib fracture. There were 212 residents residing in the facility at the time of the survey. The findings include.Observation of the vehicle involved in the incident was not completed because it was not available on site during the survey. Record review of the Agency for Healthcare Administration Immediate Report submitted 01/21/2026 at 6:30 PM indicated: Type of Incident- Serious Bodily Injury; Description of Incident: On 01/21/2026, the resident's son informed the nurse supervisor that the resident stated to him that during his transportation ride to his scheduled oncology appointment, he fell in the van. The resident's son stated that after the resident was seen and evaluated at his appointment, he was transferred to the hospital via ambulance where it was determined that the resident had sustained a fracture of the ribs. Review of the nursing progress notes for Resident # 7 dated 01/21/2026 timestamped 07:00 AM documented: Resident left the facility for a medical appointment at the 7:00 AM with facility transportation. Resident's vital signs were stable. Respirations even and unlabored, no shortness of breath or distress noted, resident verbalized no pain or discomfort at the time. skin warm and dry to touch. No signs of hyperglycemia or hypoglycemia observed. Progress note dated 01/21/2026 timestamped 06:30 PM documented: Resident departed the facility at 7:00 AM for a previously scheduled appointment at the hospital utilizing facility transportation services. Prior to departure, resident was assessed and found to be in stable condition, with vital signs within normal limits and no complaints of pain, discomfort, dizziness, or distress noted at the time. At 4:30 PM, the resident's son arrived at the facility and reported that he had been informed by the Transportation Driver (Staff A) that the resident had fallen inside the vehicle. According to the resident son, the resident was initially transported to one hospital where an X-ray revealed pneumothorax, afterwards the resident was subsequently transferred to another hospital where he was admitted for further medical management and monitoring. Upon receiving this information, the facility supervisor and physician were promptly notified of the incident and the resident's current hospitalization status. The oncoming nurse will be notified to follow-up. Review of Resident #7 medical records revealed the resident was initially admitted to the facility on [DATE], readmitted on [DATE]. Clinical diagnoses included but not limited to:1/28/2026-Traumatic Pneumothorax, subsequent encounter, 01/28/2026-Traumatic Hemothorax, subsequent encounter. 1/28/2026-Multiple fracture of wings, right side, encounter for fracture with routine healing. Chronic Obstructive Pulmonary Disease (COPD) with (acute) exacerbation. Acute and Chronic Respiratory Failure with Hypoxia and Hypercapnia Emphysema. Malignant Neoplasm of upper lobe, right bronchus or lung. Shortness of Breath. Resident #7 was discharged on 01/21/2026. Review of the Physician's Orders Sheet for January 2026 revealed Resident #7 had orders that (continued on next page)

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 0689 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	included but not limited to: Oxygen via nasal cannula at 2 liters per minute (l/min) as needed for oxygen saturation (sp02) less than 92% related to Acute and Chronic Respiratory Failure with Hypercapnia. Montelukast Sodium 10 milligrams (mg) one (1) tablet by mouth related to COPD. Theophylline 300 mg extended release- one (1) tablet by mouth every 12 hours for COPD. Gel cushion when in wheelchair for comfort every shift. Record review of Resident #7 's Discharge Return Anticipated Minimum Data Set (MDS) dated [DATE] revealed: the resident is Cognitively intact; Functional Abilities section documented the resident is dependent on care, always incontinent of bowel and bladder. Health Conditions documented the resident had one fall with major injury. Section for Medications documented the resident is receiving Antidepressant, Hypnotic, Antiplatelet, Hypoglycemic. Special Treatments and Procedures documented the resident is receiving oxygen therapy. Record review of Resident #7 's Care Plans Reference Date 01/28/2026 revealed: Resident/family/caregiver were educated on fall reduction strategies. Patient will ask for assistance when assistance is needed. Patient will assist staff to maintain a safe environment. Patient will comply with staff instructions Patient will keep bed in low position. Patient will keep environment clutter free. Resident will use call light when assistance is needed. Review resident's medication regimen as needed. Skilled therapy evaluations and treatments as ordered by physician. Staff to assist resident with wheelchair safety to reduce risk of fall and injury every shift. Interview on 01/28/2026 at 4:36 PM, the facility's Transportation Driver (Staff A) stated: On 01/21/26 in the morning on my way to drop the resident [Resident #7] from the facility to a medical appointment close to [local hospital] the following events occurred. -I transported the resident from his room at the facility and took him to the transport vehicle at the entrance of the facility, I placed the resident in his wheelchair on the vehicle lift and raised him up into the vehicle, I secured the wheelchair with four (4) straps to the wheelchair, grounded to the floor of the vehicle, and a belt around his waist secured to the wheelchair. I began driving the resident to his appointment, when I was approximately a block away, I heard a noise at the back of the vehicle, I looked back into the vehicle and saw the resident lying on his left side on the floor of the vehicle, still in his wheelchair. I stopped the vehicle, went to the back where the resident was, I unhooked the seatbelt around the resident's waist, left the resident on the floor, placed the wheelchair in an upright position, and then placed the resident back into the wheelchair and secured the resident the same way I did at the beginning of the trip. Once the resident was secured, I continued to the appointment that was approximately a minute away. When I got to the appointment destination I met the resident's son, I told the resident's son what happened, he spoke to his father, the resident stated he was ok and the son told me it was ok to leave, then I left. I found out later that the resident's son called the facility and let someone at the facility know what happened. After I left the appointment, I came back to the facility. When I returned to the facility I did not report what had happened with the resident in the vehicle. On my way home that day the facility called and told me the resident's son reported to them what had happened and I needed to make a report. The next day I came to the facility to make a report of the events that happened with the resident the day before, after I made my report, I was told that I was on suspension pending the results of the investigation. Currently I am still on suspension. I was only supposed to drop the resident off to his appointment, the resident's son usually spends the day with him after his appointments and bring him back to the facility afterwards.During an interview on 1/28/2026 at 6:27 PM, the Risk Manager, Assistant Administrator (NHA)/Abuse Coordinator revealed that on 01/21/2026 at approximately at 6:30 PM Resident #7's son came to the facility and spoke to Registered Nurse Supervisor (Staff B)-he reported that his dad was at the hospital and on that morning he met the transport driver (Staff A) at his (continued on next page)

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