STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	425082	A. Building B. Wing	06/11/2026

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Riverside Health and Rehab	2375 Baker Hosp Blvd Charleston, SC 29405

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 0610 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Respond appropriately to all alleged violations. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, interview, record review, and facility policy, the facility failed to fully investigate an allegation of staffˆtoˆresident abuse. Specifically, the facility did not conduct a record review related to the alleged violation to acknowledge that the incident occurred. There were no clinical progress notes, incident reports, or Care Plan updates, for 1 of 5 residents reviewed for abuse, Resident (R)7. This failure has the potential to result in continued psychosocial harm or place the resident at risk for further abuse. Findings include:Review of the undated facility policy titled, Organizational Ethics, Abuse, Neglect, and Misappropriation of Property, states, III. Prevention: 5. Ongoing assessment, care planning, and monitoring of those patients/residents with special needs that may lead to abuse or neglect. Component IV: Investigation 5. E. Employees/witnesses will be interviewed by designated facility staff and the interviewer will record all witness accounts in a document, written, dated, and signed by the interviewer. Guidelines for Investigation: H. Social Service will provide support services to resident/patient and implement an interdisciplinary care plan.Review of the facility policy titled, Care Plan Process, Person Centered Care, with a complete revision date of May 5, 2023, states, Thru ongoing assessment, the facility will initiate person-centered care plans when the resident's clinical status or change of condition dictates. 11. The person-centered care plan includes: E. Interventions, discipline-specific services, and frequency.Review of the facility policy titled, Social Services, with a complete revision date of June 9, 2023, states, Allegations of Abuse, Neglect, or Exploitation: Abuse may result in increased psychosocial needs displayed by behavioral or psychosocial outcomes including, but not limited to, the following: .including aggressive or disruptive behavior toward a specific person. Document psychosocial well-being related to allegations of abuse or neglect to ensure no psychosocial harm. Monitor and document for a minimum of 72 hours. Care Plan: Social Services will develop or revise resident/patient care plans if the resident's mental or psychosocial needs or preferences change as a result of an incident of abuse, neglect, or exploitation. Will add a care plan to monitor for the next 90 days at minimum for any psychosocial impact or unmet needs.Review of R7's Face Sheet revealed she was admitted to the facility on [DATE] with diagnoses including, but not limited to, contracture, muscle weakness, need for assistance with personal care, cognitive communication deficit, restlessness and agitation, and depression.Review of R7's quarterly Minimum Data Set (MDS) with an Assessment Reference Date (ARD) of 04/02/26 reveals she had a Brief Interview of Mental Status (BIMS) of 12 out of 15, indicating she had moderate cognitive impairment. Review of R7's Progress notes did not include any information pertaining to the alleged incident that was investigated by the abuse coordinator.Review of R7's Care Plan did not include any information pertaining to the alleged incident that was investigated by the abuse coordinator.Review of R7's Electronic Health Record (EHR) did not include an incident report, or social services assessments or reports that provided any information pertaining to the alleged incident that was investigated by the abuse coordinator.During an interview on 06/11/26 at 11:15 AM, R7 revealed that a CNA hit her in the face twice; she was not aware of her name. I told her she wasn't going to be hitting and jerking on me. She was handling me rough and I told her to stop. I was in the wheelchair, and she kept pushing me back and I would push back against her and I hit at her. She called the nurse (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 0610 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	because I wouldn't let her help me. I saw her the night before last, but she doesn't help me anymore, but she will roll her eyes at me when she sees me. Social Services did not come to assist her after the incident, but she states she feels safe and doesn't feel threatened. The doctor came and assessed her that day. She indicates that her left leg hurts sometimes but they give her pain medication for that. She stated she wanted to call her daughter that night and one of the nurses helped me at the desk to call her. During an interview on 06/11/26 at 1:46PM, the Director of Social Services revealed, If there were speculation of abuse I would report to administration right away, separate residents, and if need be, I would call local law enforcement. We would assess the resident and contact Emergency Medical Services (EMS) if needed. My role would be to evaluate if there needs to be a room change and provide daily checks each day after the incident to see how they are doing emotionally and/or mentally. I would also follow up if a mental health referral is needed. If I was involved in the situation then I would put in a progress note. Anything after the incident, I would document and usually update the care plan if it was a behavioral issue. I don't see any progress notes related to R7, and I don't recall any incidents with her. She is usually a quiet resident. Information about the incident would have been provided in the morning rounds, that is where we would discuss hospitalizations, deaths, changes of condition, new residents, grievances, falls, and resident radar. It's a 24-hour report about anything that may have changed with the residents in the facility. I wasn't involved in the alleged situation with R7, and I didn't know that happened.During an interview on 06/11/26 at 2:07 PM, the Assistant Director of Nursing (ADON) revealed in the morning meetings we discuss grievances, complaints, schedules for staff, nursing staff rundown or significant events. I am not involved in the investigation process, if there were allegations of abuse, we would notify the social worker, and we must notify the administrator. During an interview on 06/11/26 at 2:15 PM, the Facility Administrator (FA) stated, Morning meetings are at 9AM to discuss discharges and admissions, and anything clinical that happened the previous day. Rounds and IDT team meetings help determine any new information about the residents. They discuss what is going on and what we will be investigating. The clinical regional nurse, and DON, assist with investigations and the staff development coordinator will also assist if they have to reeducate the staff. Incidents are reported by the nursing department for every incident. After incidents, we usually update the care plan, and this would be completed by MDS or nursing management. Social Services will assist if someone may need therapy or a room change initiated, and they would also be responsible for psychosocial treatment, and they could update their care plan if needed.During an interview on 06/11/26 at 2:23 PM, the MDS Coordinator revealed she receives updates about resident status through email or morning meetings, or by stopping by a unit and information can be relayed that way also. The Care Plan is established to identify what needs to happen to the residents. The DON and Social Services are involved with any changes. The MDS Coordinator stated she would look to see if there have been any changes or updates to the MDS about R7 and let the surveyor know. The MDS Coordinator did not provide any information following this interview.During an interview on 06/11/26 at 3:13 PM, the FA revealed the incident didn't happen with nursing, that is why there wouldn't be any incident reports or notes about the incident. Nurses stated they didn't know anything about it until he informed them the next day after I had received a call from her daughter. Because I notified them of the situation, I can't say that it would be classified as an incident. An allegation of abuse is not seen as an incident, because it was provided initially by the daughter.