STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	065165	A. Building B. Wing	04/30/2026

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Riverbend Health and Rehabilitation Center	821 Duffield CT Loveland, CO 80537

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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0812 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	Procure food from sources approved or considered satisfactory and store, prepare, distribute and serve food in accordance with professional standards. Based on observations and interviews, the facility failed to ensure that food and beverages were stored, distributed, and served in accordance with professional food safety standards in the main kitchen.Specifically, the facility failed to ensure:-The kitchen was kept in a sanitary manner; and,-Condiments were labeled when opened. Findings include:I. Failure to ensure the kitchen was clean and kept in a sanitary mannerA. Professional reference The Colorado Department of Public Health and Environment Colorado Retail Food Establishment Rules and Regulations, revised 3/16/24, was retrieved on 5/6/26. It revealed in pertinent part, Physical facilities shall be cleaned as often as necessary to keep them clean. Plumbing fixtures such as handwashing sinks, toilets, and urinals shall be cleaned as often as necessary to keep them clean. Intake and exhaust air ducts shall be cleaned and filters changed so they are not a source of contamination by dust, dirt, and other materials. Floors, floor coverings, walls, wall coverings, and ceilings shall be designed, constructed, and installed so they are smooth and easily cleanable. Refuse, recyclables, and returnables shall be removed from the premises at a frequency that will minimize the development of objectionable odors and other conditions that attract or harbor insects and rodents. Equipment, food-contact surfaces and utensils shall be clean to sight and touch. (Chapter 4, 5, and 6) B. Facility policy and procedureThe Kitchen Sanitation and Cleaning policy, dated August 2023, was provided by the nursing home administrator (NHA) on 4/30/26 at 5:09 p.m. It read in pertinent part, All dietary staff were expected to always use good hygienic practices and to follow all established cleaning and sanitation procedures. Cleaning and sanitation tasks for the kitchen will be outlined in a written cleaning schedule. Cleaning is necessary to protect against microorganisms. Food-contact surfaces shall be cleaned in this sequence: wash with detergent, rinse with clear water, and then use an approved sanitizer. The sanitizer used should be approved for use on food-contact surfaces and must be mixed according to the manufacturer's directions. Cleaning should be performed before, during and after food preparation. Each user must properly clean and sanitize the kitchen after their shift and ensure it is ready for the next user. Tables, stove-tops, oven fronts, dirtied walls, and cooler doors should be washed with hot soapy water, wiped with clean towels, sanitized, and wiped again with clean towels or air-dry.C. ObservationsThe initial kitchen walkthrough was completed on 4/27/26 at 8:55 a.m. The following was observed:-Accumulation of dust on the lower shelf of the tray line table with multiple clean pans and lids nested together directly on the dusty surface.-A rusty pipe extending from the south wall, where an opening in the structure had created a gap between the wall and the pipe. -A ventilation outlet located at the center of the food preparation area was rusted and had visible brown stains present on the air passage surfaces, posing a risk of physical contaminants or debris falling into open food.-A hole was observed on a door frame leading to the kitchen manager's office and the door to the chemical storage room in the kitchen had a missing handle. -The three-compartment sink had white stains and condensation. Underneath the sink was an overflow of dirty cleaning rags in a plastic container.-The ceiling above the kitchen stove had dark yellowish stains spread across the entire surface, directly over the food preparation area.-Missing floor tiles in the dishwashing room.II. Ensured beverages were properly labeled when opened.A. Professional referenceThe Colorado Retail (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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	065165	A. Building B. Wing	04/30/2026

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F 0812 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	Food Establishment Rules and Regulations, (3/16/24), retrieved on 5/6/26 read in pertinent part, A date marking system that meets the criteria may include: Using a method approved by the Department for refrigerated, ready-to eat potentially hazardous food (time/temperature control for safety food) that is frequently rewrapped, such as lunch meat or a roast, or for which date marking is impractical, such as soft serve mix or milk in a dispensing machine; marking the date or day of preparation, with a procedure to discard the food on or before the last date or day by which the food must be consumed on the premises, sold, or discarded; marking the date or day the original container is opened in a food establishment, with a procedure to discard the food on or before the last date or day by which the food must be consumed on the premises, sold, or discarded or using calendar dates, days of the week, color-coded marks, or other effective marking methods, provided that the marking system is disclosed to the department upon request. (Chapter 3-29).B. Facility policy and procedureThe Food Storage policy, revised May 2025, was provided by the NHA on 4/30/26 at 5:09 p.m. It read in pertinent part. Prepared foods should be used or discarded within seven days. Foods shall be labeled, dated, and covered. Dates used may be a date prepared/opened and/or used by date.C. ObservationsThe initial kitchen walkthrough was completed on 4/27/26 at 8:55 a.m. The following was observed in the walk-in refrigerator:-Two opened Kogi bar-b-que sauces that were not dated;-An opened Caesar salad dressing that was not dated; and,-An opened enchilada sauce that was not dated.III. Staff interviewsThe dietary manager (DM) was interviewed on 4/30/26 at 9:20 a.m. The DM said several work orders had been completed and that the maintenance department was working to repair the broken door handle and replace the missing floor tiles in the dishwashing room. The DM said he did not know why they failed to label the identified items stated above. He said he would immediately update the cleaning schedule to include more days for deep cleaning.Regional resource dietitian #1 and regional resource dietitian #2 were interviewed together on 4/30/26 at 9:35 p.m. Regional resource dietitian #2 said she had updated the kitchen cleaning schedule and would provide education to ensure it was followed. Regional resource dietitian #2 said opened beverages should never be stored undated because they present a safety and quality risk. She said an open beverage with no date makes it impossible to determine whether the product had exceeded its safe shelf life, posing a significant risk of contamination. Regional resource dietitian #1 said the staff should never store food and beverages without proper labeling to prevent contamination. She said they would immediately provide education and monitoring of the kitchen staff.The NHA was interviewed on 4/30/26 at 2:45 p.m. The NHA said she was informed by the regional resource dietitian #2 about the identified sanitary conditions in the kitchen and the kitchen staff's failure to label beverages in the walk-in refrigerator. The NHA said the facility would immediately initiate corrective actions to address all identified food storage and kitchen sanitation concerns.

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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0602 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Protect each resident from the wrongful use of the resident's belongings or money. Based on observations, record review and interviews, the facility failed to prevent misappropriation of property for five (#79, #48, #3, #102 and #51) of five residents reviewed for misappropriation of property out of 51 sample residents.Specifically, the facility failed to prevent the theft of Resident #79, Resident #48, Resident #3, Resident #102 and Resident #51's narcotic medications.Findings include:Record review, observations and interviews confirmed the facility corrected the deficient practice prior to the onsite investigation on 4/27/26 to 4/30/26, resulting in the deficiency being cited as past non-compliance with a correction date of 4/22/26.I. Incident of drug diversion on 3/13/26On 3/13/26 at approximately 1:00 p.m. the director of nursing (DON) overheard the nurse on the front east hall in a discussion with Resident #79 about his scheduled narcotic being unavailable. The DON confirmed that there was no narcotic medication available for Resident #79 and the dispensing pharmacy was notified on 3/13/26 about Resident #79's missing medication. The dispensing pharmacy informed the facility that Resident #79's 60 oxycodone pills (two medication cards) were sent to the facility on 3/4/26 and a sufficient supply of the medication should have been available on 3/13/26 for the resident. The dispensing pharmacy provided a new three-day supply of the narcotic medications for Resident #79 on 3/13/26 and the nurse dispensed the resident's narcotic medication from the automated dispensing system until the three-day supply arrived at the facility. Resident #79's pain did not go unresolved on 3/13/26.The DON further reviewed Resident #79's narcotic medication records in order to determine when the resident's last oxycodone medication card had been completed (last medication administered from the medication card) and removed from the medication cart. The DON identified that licensed practical nurse (LPN) #3 had completed Resident #79's oxycodone medication card and removed it from the medication card on 3/12/26, earlier than the card should have been completed.On 3/16/26, the DON expanded the narcotic medications investigation on and found further discrepancies between with the pharmacy's narcotic medications delivery logs and the with facility's narcotic medications logs for Resident #79, Resident #48, Resident #3, Resident #102 and Resident #51.The facility's investigation identified there were approximately 350 to 500 oxycodone and norco narcotic medications that were unaccounted for between 1/7/26 and 3/16/26.II. Facility plan of correctionThe plan of correction the facility put in place in response to the drug diversion incident was provided by the regional clinical resource on 4/30/26 at 5:05 p.m. The plan included the following: A. Immediate action to correct the deficient practiceOn 3/13/26, after learning the pharmacy had sent 60 oxycodone pills for Resident #79, so there should have been pills remaining, the DON investigated the missing narcotics for the resident and identified LPN #3 had completed the resident's oxycodone medication card on 3/12/26, but pills should have still been in the medication card.On 3/13/26 the pharmacy was notified of the concern and sent an additional three-day supply of oxycodone for Resident #79.On 3/13/26 LPN #3 was interviewed by the DON and the NHA and based on that interview, LPN #3 was suspended and sent for a drug test.On 3/16/26 the preliminary drug test results for LPN #3 revealed she tested non-negative for oxycodone and the test was sent to the laboratory for final confirmation of the results.On 3/17/26 the facility terminated LPN #3. On 3/25/26 the final drug testing results confirmed LPN #3 had tested positive for oxycodone. On 4/22/26 the pharmacy consultant conducted a full-house audit of the facility's controlled substances. The narcotics were being stored securely, there were no discrepancies in narcotic medication counts noted, no tampering of medication containers was observed, narcotics were being logged into inventory upon receipt and nursing staff were conducting change of shift counts per policy and regulation. B. Identification of other residentsOn 3/16/26 the DON completed continued investigating and identified further discrepancies between the pharmacy's narcotic medications delivery logs and the facility's narcotic medications logs for Resident #79, Resident #48, Resident #3, Resident #102 and Resident #51. C. Systemic changesOn 3/17/26 education was initiated with the nursing staff. The ongoing education included the new process (continued on next page)

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	065165	A. Building B. Wing	04/30/2026

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F 0602 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	implemented for the empty narcotic medication bubble packs, education regarding the narcotics logs and education related to signs of drug diversion.The pharmacy consultant would begin reviewing the facility's narcotics and sending the findings to the facility.The pharmacy would only be sending one card of narcotic medication for residents, instead of two cards, each time the prescription was refilled.D. MonitoringThe DON would complete audits to monitor all controlled substances, including comparing the pharmacy narcotics logs to the facility's narcotics logs. Empty narcotics bubble packs would be turned into the DON along with the narcotics log, and then the DON would compare the logs. The audits would be conducted daily until compliance was met.The audits would be discussed in the facility's monthly quality assurance and performance improvement (QAPI) for a minimum of three months.III. Facility policy and procedureThe Drug Diversion and Response policy, revised January 2026, was provided by the regional clinical resource on 4/30/26 at 5:05 p.m. It revealed in pertinent part, Suspicion of drug diversion may arise from a variety of circumstances including, but not limited to:-A witnessed incident of probable drug diversion,-Suspicious activity identified during routine monitoring or proactive surveillance; or,-Self disclosure.Controlled medications are substances that have an accepted medical use (medications which fall under US Drug Enforcement Agency (DEA) Schedules II-IV), have a potential for abuse, ranging from low to high, and may also lead to physical or psychological dependence.Residents have the right to be free from theft and/or misappropriation of personal property.Diversion of medications is defined as using or taking possession of a controlled substance, prescription medication, or medical gas from residents' prescriptions, E-Kit (emergency kit) or secured medication waste devices intentionally without proper authorization or the transfer of a controlled substance from a lawful to an unlawful channel of distribution or use (as adapted from the Uniform Controlled Substance Act - 1994).The Investigating Incidents of Theft and/or Misappropriation of Resident Property policy, revised January 2026, was provided by the regional clinical resource on 4/30/26 at 5:05 p.m. It read in pertinent part, Residents have the right to be free from theft and/or misappropriation of personal property.Train staff to educate them about activities that constitute and procedures for reporting abuse,neglect, exploitation and misappropriation of resident property. IV. Facility investigationThe facility investigation of the misappropriation of residents' narcotics was provided by the nursing home administrator (NHA) on 4/29/26 at 9:00 a.m.The investigation documented that on 3/13/26 at approximately 1:00 p.m. the DON overheard the nurse on the front east hall in a discussion with Resident #79 about his scheduled narcotic being unavailable. The DON confirmed that there was no narcotic medication available for Resident #79 and the dispensing pharmacy was notified on 3/13/26 about Resident #79's missing medication. The investigation documented the dispensing pharmacy informed the facility that 60 oxycodone pills (two medication cards) were sent to the facility on 3/4/26 and a sufficient supply of the medication should have been available on 3/13/26 for the resident. The dispensing pharmacy provided a new three-day supply of the narcotic medication for Resident #79 on 3/13/26 and the nurse dispensed the resident's narcotic medication from the automated dispensing system until the three-day supply arrived at the facility. Resident #79's pain did not go unresolved on 3/13/26. The investigation documented the DON further reviewed Resident #79's narcotic medication records in order to determine when the resident's last oxycodone medication card had been completed and removed from the medication cart. The DON identified that LPN #3 had completed Resident #79's oxycodone medication card and removed it from the medication card on 3/12/26, earlier than the card should have been completed. Upon further investigation, the DON discovered 36 oxycodone 10 milligram (mg) pills were missing from Resident #79's narcotic medication count. LPN #3 was interviewed by the DON on 3/13/26. The investigation identified that the DON had concerns with the information provided by LPN #3 during her interview and discussed her concerns with the NHA on 3/13/26. The NHA and the DON then interviewed LPN #3 a second time on 3/13/26 at approximately 4:25 p.m.The investigation identified that LPN #3 was suspended following the interview and sent by the facility for drug testing. The NHA followed up with the drug testing service on 3/16/26 and was informed LPN #3's drug test results were non-negative (continued on next page)

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	065165	A. Building B. Wing	04/30/2026

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F 0602 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	for oxycodone and were sent to the laboratory for confirmation of final. The investigation revealed the DON expanded the narcotic medications investigation on 3/16/26 and found further discrepancies between the pharmacy's narcotic medications delivery logs and the facility's narcotic medications logs for Resident #79, Resident #48, Resident #3, Resident #102 and Resident #51. The DON's expansion of the narcotic medications investigation identified there were approximately 350 to 500 oxycodone and norco narcotic medications that were unaccounted for between 1/7/26 and 3/16/26. During the expanded investigation on 3/16/26, the DON identified that LPN #3 received the 60 oxycodone pills (two medication cards) for Resident #79 on 3/4/26 and entered the medications on the facility's narcotic log. However, the pharmacy sent two medication cards of oxycodone for the resident and LPN #3 only logged one card on the facility's narcotic log. Additionally, LPN #3 completed the medication card on 3/12/26 and removed from the medication cart, however, the card should have had six pills remaining when the card was removed from the medication cart.Additional findings during the DON's narcotic medications investigation expansion on 3/16/26 were as follows:The investigation documented LPN #3 completed residents' medication cards and removed them from the facility's narcotic log on 1/7/26, 1/16/26, 1/17/26, 1/29/26, 2/5/26, 2/7/26 (two cards), 2/8/26, 2/12/26 (two cards), 2/19/26, 2/22/26, 2/23/26, 2/27/26, 2/28/26, 3/4/26 (three cards), 3/7/26 and 3/8/26. However, individual narcotics logs could not be located for each of the medication cards.The conclusion of the DON's investigation identified the following residents were missing narcotics:-Resident #79 was missing 36 oxycodone hydrochloride (HCL) 10 mg pills; -Resident #48 was missing 58 oxycodone HCl 5 mg pills;-Resident #3 was missing 130 norco 10-325 mg pills;-Resident #102 was missing 102 oxycodone HCl 5 mg pills; and, -Resident #51 was missing 128 oxycodone HCl 5 mg pills.V. Record reviewAn inservice training document titled Narcotic Logs was provided by the DON on 4/30/26 at approximately 3:00 p.m. The education read in pertinent part,It is the responsibility of all nurses to ensure that all completed narcotics are logged and narcotic bubble packs are attached to narcotic sheets and turned into the DON. The document was signed by 19 combined registered nurses (RN), LPNs and certified nurse aides with medication authority (CNA-Med) on 3/16/26.An inservice training document titled Warning Signs of Drug Diversion was provided by the DON on 4/30/26 at approximately 3:00 p.m. The document was signed by 30 RNs, LPNs and CNAs on 3/16/26.VI. Staff interviewsThe DON, the regional clinical resource and the pharmacy consultant were interviewed together on 4/30/26 at 12:27 p.m.The DON said the facility's investigation of the drug diversion incident began on 3/13/26 when she heard a nurse on the front east hall discussing Resident #79's scheduled narcotic medication being unavailable.The DON and the facility pharmacist consultant said the dispensing pharmacy and the pharmacy consultant were notified of the missing narcotic medications on 3/13/26. The DON said the facility's investigation included narcotic medications log audits, nurse manager and nurse interviews, and interviews of the involved staff. The pharmacy consultant said the investigation revealed the dispensing pharmacy had provided an excess of resident narcotic medication cards at one time, which allowed for easier manipulation of inventory and log count numbers. The DON said the investigation revealed LPN #3 was involved in every narcotic count discrepancy identified during the investigation and this led to the facility concluding LPN #3 was responsible for the missing narcotic medications.The DON said LPN #3 was terminated from employment at the facility. The DON said no residents were harmed when the narcotics were diverted, and no narcotic pain medication administrations were missed. The DON said the drug diversion reported on 3/13/26 was substantiated by the facility.VII. Additional facility follow-up The DON provided additional education that was developed and presented to the nursing staff by the pharmacy consultant on 4/30/26. The documentation was provided by the DON on 4/30/26 at 3:35 p.m. The education was regarding new facility controlled substances processes, including receiving controlled medications and the controlled substance medication count. The education was as follows:The nurse receiving the controlled medications from the dispensing pharmacy should check the pharmacy information for accuracy. The receiving nurse would sign and (continued on next page)

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	065165	A. Building B. Wing	04/30/2026

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Riverbend Health and Rehabilitation Center	821 Duffield CT Loveland, CO 80537

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F 0602 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	date the pharmacy shipping manifest if it was accurate. Any discrepancies would be reported immediately to the DON and the dispensing pharmacy. At shift change, or anytime there was a change of responsibility, both off-going and on-coming nurses would complete a controlled medication count. Both off-going and on-coming nurses would visually inspect each controlled substance medication for security and count accuracy. This inspection was to include an examination of each medication for tampering, color, clarity, consistency and expiration date. Failure to inspect each controlled substance medication for accuracy would result in disciplinary action, including termination. Two signatures were needed on the change of shift controlled substance sheet verifying accuracy. The nurses' signatures were verification that each controlled substance medication container and count was accurate with no concerns noted.

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	065165	A. Building B. Wing	04/30/2026

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F 0554 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Allow residents to self-administer drugs if determined clinically appropriate. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observations, record review and interviews, the facility failed to ensure the self-administration of medications was clinically appropriate for one (#65) of one resident out of 51 sample residents.Specifically, the facility failed to ensure Resident #65 was assessed for self-administration of Visine eye drops and DeepSea nasal saline.Findings include:I. Facility policy and procedureThe Self Administration of Medications policy, undated, was provided by the nursing home administrator (NHA) on 4/30/26 at 5:09 p.m. It revealed in pertinent part, All residents who desire to self-administer medication may do so if deemed safe by the provider and the facility. The resident must follow all facility policies for self-medication.The facility shall compile a list of all resident medications along with any known allergies and verify the accuracy and completeness of the list with the resident and authorized practitioner at the time of admission.The facility shall review this list with the resident and authorized practitioner at least once a year and maintain documentation of such review.The facility will perform an evaluation of resident's ability to self-administer safely upon admission, quarterly, and with a significant change. An evaluation may also be done if a new medication is ordered or if the staff believes the resident is not administering the medication safely.The facility shall report non-compliance, misuse, or inappropriate use of known medications by a resident who is self-administering to that resident's authorized practitioner and responsible party if applicable.Any resident deemed safe to self-administer medications will have an assessment and a quarterly updated care plan.Failure to administer and/or store medications safely may result in the facility and provider removing the self-administration order.II. Resident #65A. Resident statusResident #65, age greater than 65, was admitted on [DATE]. According to the April 2026 computerized physician orders (CPO), diagnoses included osteoarthritis (chronic joint disease), spinal stenosis, hypertension, major depressive disorder, generalized anxiety disorder and muscle weakness.The 3/11/26 minimum data set (MDS) assessment revealed the resident was cognitively intact with a brief interview for mental status score (BIMS) of 15 out of 15. She required staff supervision for toileting and transfers, moderate assistance with personal hygiene, and set-up assistance with eating.B. Resident observation and interviewOn 4/28/26 at 10:04 a.m. Resident #65 was sitting in her power wheelchair in her room, facing her bed and the bedside drawer. The drawer was partially opened, revealing a bottle of DeepSea nasal saline and a bottle of Visine eye drops inside. Resident #65 said she used the medications by herself, so she kept them in her drawer. She said she used the medications frequently every day but did not remember how many times she used them per day. Resident #65 said the facility staff was aware of the medications in her drawer.C. Record reviewReview of Resident #65's April 2026 electronic medication administration records (EMAR), from 4/1/26 to 4/29/26, revealed no documentation to indicate that the Visine eye drops and the DeepSea nasal saline had been administered to the resident.-However, Resident #65 said she used the Visine eye drops and DeepSea nasal saline every day. (see resident interview above).-Review of Resident #65's electronic medical record (EMR) did not reveal that an assessment for the self-administration of Visine eye drops and DeepSea nasal saline had been completed for the resident.-Review of Resident #65's April 2026 CPO revealed there was no active physician's order for the Visine eye drops and the DeepSea nasal saline.III. Staff interviewsRegistered nurse (RN) #1 was interviewed on 4/30/26 at 9:15 a.m. RN #1 said Visine eye drops and DeepSea nasal saline were medications and required a physician's order to administer. RN #1 said Resident #65 required assessment to deem her safe to administer her own medication before being allowed to have medication in her possession. RN #1 said Resident #65 did not have a physician's order for the Visine and DeepSea nasal saline. RN #1 said she would immediately inform her supervisor and remove the medications from the resident's bedside drawer until it was deemed safe for her to have the medications in her possession.The director of nursing (DON) and the regional clinical resource were interviewed together on 4/30/26 at 10:45 a.m. The DON (continued on next page)

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	065165	A. Building B. Wing	04/30/2026

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F 0554 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	said Visine eye drops and DeepSea nasal saline were medications and required a physician's order and a resident assessment in order for them to be self-administered and made available to Resident #1 in her bedside drawer. The DON said she was notified by RN #1 of the absence of a physician's order and immediately placed an order for the Visine eye drops and the DeepSea nasal saline. The DON said without an assessment, there was no monitoring for side effects or drug-to-drug interactions The regional clinical resource said all medications should be stored in a secure area, out of reach of all residents, unless otherwise indicated. She said medications kept at residents' bedsides were prone to contamination. She said if a resident touched the tip of a Visine bottle to an infected eye and continued to use it, or if another resident gained access to the bottle, it would create a significant infection control hazard. The regional clinical resource said the facility would immediately provide education to clinical staff to ensure medications were stored in a secure location. She said the facility would ensure all residents' medications had the required physician's orders and safety assessments for self-medication administration.

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	065165	A. Building B. Wing	04/30/2026

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F 0568 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Properly hold, secure, and manage each resident's personal money which is deposited with the nursing home. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on record review and interviews, the facility failed to provide evidence that a quarterly statement was provided to residents and/or resident representative to establish and maintain a system that assures a full and complete, generally accepted accounting principles, of each resident's personal funds entrusted to the facility on the resident's behalf for one (#65) of one resident reviewed for personal funds out of 51 sample residents.Specifically, the facility failed to provide Resident #65 with a copy of her personal funds statement on at least a quarterly basis.Findings include:I. Facility policy and procedureThe Accounts Receivable policy and procedure, revised 1/1/26, was provided by the nursing home administrator (NHA) on 5/4/26 at 1:12 p.m. It read in pertinent part, This procedure defines the standardized process for managing and monitoring Resident Trust Funds (RTF), ensuring residents have appropriate access to their funds while safeguarding those assets in full compliance with applicable state and federal regulations. It promotes consistency, transparency, and accountability in the administration of resident finances. The facility will send out the RTF statement to the resident or the resident's legal representative within 30 days from the end of the quarter or as specified by the state or in the federal regulations.The business office will keep a copy of the quarterly statements sent to the residents or their legal representatives.The facility's executive director will be responsible for ensuring quarterly statements are submitted in a timely manner and in accordance with State or Federal regulations.II. Resident trust fund authorizationThe Authorization and Agreement to Manage Resident Funds form read in pertinent part, By my signature below, I hereby authorize the facility named above to establish and manage a federal deposit insurance corporation (FDIC) insured interest-bearing resident fund or burial account with the options specified above. I understand that I may have my recurring checks deposited into my resident fund account, that I may make deposits to and withdrawals from my resident fund account at the facility, and that I will receive a statement of any account I have at least quarterly.III. Resident #65A. Resident statusResident #65, age greater than 65, was admitted on [DATE]. According to the April 2026 computerized physician orders (CPO), diagnoses included osteoarthritis (chronic joint disease), spinal stenosis, hypertension, major depressive disorder, generalized anxiety disorder and muscle weakness.The 3/11/26 minimum data set (MDS) assessment revealed the resident was cognitively intact with a brief interview for mental status score (BIMS) of 15 out of 15. B. Resident interviewResident #65 was interviewed on 4/27/26 at 3:16 p.m. Resident #65 said she was her own financial responsible person, but she said she had never received a statement about her personal funds account since admitting to the facility over a year and a half ago. She said she often went to the business office to ask them verbally whenever she wanted to know her account balance, and the business office manager would verbally tell her the balance. C. Record reviewA request was made on 4/29/26 for documentation to indicate when Resident #65 received her quarterly statements. -However, the business office manager was unable to provide documentation that indicated when Resident #65 received her personal funds account balance statements on a quarterly basis (see interviews below).IV. Staff interviewsThe business office manager was interviewed on 4/29/26 at 2:14 p.m. The business office manager said Resident #65 was her own financially responsible person. She said the resident often stopped by the business office to verbally request her personal funds account balance. The business office manager said she prepared the personal funds account balances of all residents who had a trust account with the facility, but she said she did not send balance statements out to the residents or their representatives. The business office manager said the facility managed the finances for Resident #65 and a personal funds account balance statement should be issued to her at least quarterly. She said she thought the verbal reports she gave to the resident regarding her balance counted, however, she said she did not have documentation of when Resident (continued on next page)

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	065165	A. Building B. Wing	04/30/2026

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Riverbend Health and Rehabilitation Center	821 Duffield CT Loveland, CO 80537

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F 0568 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	#65 verbally requested her account balance.The NHA was interviewed on 4/30/26 at 11:20 a.m. The NHA said residents could request a personal funds account balance statement at any time, but it should not replace the policy of issuing quarterly statements and documenting when the statements were issued to residents or sent to their representatives. The NHA said all residents who had money managed by the facility should have received a quarterly personal funds account balance statement, including Resident #65. The NHA said the business office manager should send and document when residents' personal funds account balance statements were issued.

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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. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on record review and interviews, the facility failed to ensure one (#65) of six residents reviewed for abuse out of 51 sample residents was kept free from abuse.Specifically, the facility failed to protect Resident #65 from verbal abuse by Resident #60.Findings include:I. Facility policy and procedureThe Abuse policy, dated October 2024, was received from the nursing home administrator (NHA) on 4/27/26 at 10:41 a.m. It read in pertinent part, It is the policy of this facility that reports of abuse, neglect, misappropriation of property, and exploitation are promptly and thoroughly investigated. When an incident or suspected incident of abuse or neglect is reported, the administrator or designee will investigate the incident with the assistance of appropriate personnel. The investigation will consist of at least the following: an interview with the person(s) reporting the incident; interviews with any witnesses to the incident; an interview with the resident if possible; an interview with staff members having contact with the resident during the period/shift of the alleged incident if applicable; interviews with the resident's roommate, family members, and visitors if applicable; and, a review of all circumstances surrounding the incident. All residents and alleged victims of any pending investigation will be kept safe from any alleged assailants until an outcome of further investigation is achieved. Should the investigation reveal that abuse occurred, the administrator would report such findings to the State Licensing Agency as necessary, health department within 24 hours and police department within two hours as necessary with the results of the completion of the investigation. The administrator or designee will complete a copy of the Resident Abuse Investigation Report form within five working days of the reported incident. II. Incident of verbal abuse towards Resident #65 by Resident #60 reported on 4/7/26A. Facility investigationThe 4/7/26 facility investigation documented a verbal altercation between Resident #60 and Resident #65. The incident occurred on an unknown date in the dining room when Resident #60 passed Resident #65 and called her an inappropriate name. When interviewed by facility staff, Resident #65 said, She just says mean things to me like ?fat (expletive)' when she goes by me. I try to ignore her in the hallways but now she will come real close to me in the dining room and call me names.Resident #60 denied the incident occurred.Five staff members and 11 residents were interviewed. Those interviewed denied having an issue with Resident #60 and had not heard Resident #60 be verbally aggressive towards Resident #65. Staff abuse education was completed with 13 staff members in attendance, but only five staff completed an abuse quiz.Resident #60 was placed on frequent safety checks for three days. The residents' responsible parties, the police and the physicians were notified.The investigation documented that the facility unsubstantiated verbal abuse.-However, abuse occurred due to Resident #60 making willful verbal insults to Resident #65 causing significant emotional distress for Resident #65 (see resident's interview below). B. Resident #60 (assailant)1. Resident statusResident #60, age [AGE], was admitted on [DATE]. According to the April 2026 computerized physician orders (CPO), diagnoses included schizoaffective disorder, bipolar type and cerebrovascular accident (CVA).The 2/24/26 minimum data set (MDS) assessment revealed the resident had moderate cognitive impairment with a brief interview for mental status (BIMS) score of 10 out of 15. Resident #60 denied feeling down, depressed, or hopeless and no behaviors were documented. The MDS assessment indicated the resident received antipsychotic medication on a routine basis.2. Resident interviewResident #60 was interviewed on 4/28/26 at 9:00 a.m. Resident #60 said the incident with Resident #65 happened a few weeks ago in the dining room and she did not remember what she said to Resident #65. She said she and Resident #65 used to have rooms next to each other and they shared a bathroom. She said they had many disagreements back then so Resident #60 moved to a room on another unit. She said she continued to eat her meals in the dining room away from Resident#65. She said she ignored Resident #65 and had not had any further interactions with her.3. (continued on next page)

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F 0600 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Record reviewResident #60's trauma care plan, initiated 9/1/24 and revised 11/22/24, revealed the resident had received counseling in the past but was currently unwilling to participate. Interventions included, when the resident became agitated, intervening before the agitation escalated, guiding the resident away from the source of distress and engaging the resident calmly in conversation.Resident #60's psychosocial care plan, initiated 2/25/26, revealed the resident had the potential for a psychosocial well-being problem related to diagnosis of schizoaffective bipolar disorder and speech and language deficits. Interventions, initiated and revised on 4/27/26 (during the survey), included that social services and activities would continue to monitor and provide emotional support as needed. Triggers included others being in her space.Resident #60's behavior care plan, initiated 9/1/24 and revised 4/12/26, indicated the resident had a history of verbal aggression related to poor impulse control and schizoaffective disorder. Interventions included administering medications as ordered, notifying social services, the NHA, and the physician of increases in behavior, when the resident became agitated, intervening before the agitation escalated, guiding the resident away from the source of distress, engaging the resident calmly in conversation, if the resident's response was aggressive, staff were to walk calmly away and approach later. An intervention indicating triggers of people being in her space was initiated 4/12/26 and revised 4/28/26, during the survey. -The care plan failed to identify the episode of verbal aggression towards Resident #65 that was brought to the facility's attention on 4/7/26 (see facility investigation above) and the interventions implemented to prevent further verbal abuse incidents. A review of Resident #60's electronic medical record (EMR), from 12/1/25 to 4/30/26, failed to reveal documentation of behaviors or verbal aggression. The incident with Resident #65 was not documented in the progress notes, however, Resident #60 had been moved to a different hall in the facility following the incident. Social services progress notes on 4/7/26, 4/10/26 and 4/15/26 indicated Resident #60 said she was not fearful of anyone and stated I don't like some people but I'm not fearful. She refused behavioral health services. C. Resident #65 (victim)1. Resident statusResident #65, age [AGE], was admitted on [DATE]. According to the April 2026 CPO, diagnoses included after care following joint replacement surgery, generalized anxiety disorder, major depressive disorder and morbid severe obesity due to excess calories with a history of bariatric surgery. The 3/11/26 MDS assessment revealed the resident was cognitively intact with a BIMS score of 15 out of 15.The MDS assessment indicated the resident did not have any behaviors. The MDS assessment indicated the resident felt down, depressed, or hopeless on seven to 11 days during the assessment look-back period.2. Resident interviewResident #65 was interviewed on 4/27/26 at 3:49 p.m. Resident #65 said there had been a pattern of ongoing verbal abuse from her neighbor, Resident #60, beginning shortly after her admission to the facility. Resident #65 said Resident #60 repeatedly targeted her with derogatory insults, specifically calling her a fat (expletive) which caused her significant emotional distress. She said the repeated incidents made her sad and frustrated, and she felt that no one cared about her. She said she followed proper channels to address the situation. She said she reported the incidents first to staff members and subsequently to social services as the behaviors persisted. Resident #65 said staff assured her an investigation would take place, but she said there had been a lack of follow-up communication and the verbal abuse from Resident #60 had continued unabated. She said it was only after a subsequent report to staff about Resident #60 that the facility took definitive action and transferred Resident #60 to another unit.3. Record reviewResident #65's trauma care plan, initiated 1/29/25 and revised 4/25/25, revealed the resident had a history of verbal abuse from an ex-husband. Triggers included seeing others yelling and swearing. Interventions included approaching the resident in a calm manner, caregivers were to provide opportunities for positive interactions and attention, stopping and talking with the resident when passing by, and encouraging the resident to attend care conferences to express preferences and participate in the care plan process.-The care plan failed to identify the episode of verbal aggression from Resident #60 that was brought to the facility's attention on 4/7/26 (see facility investigation above) and the interventions implemented to prevent further verbal abuse incidents. A (continued on next page)

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	065165	A. Building B. Wing	04/30/2026

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F 0600 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	review of Resident #65's EMR, from 3/1/226 to 4/30/26, revealed the following;Review of the nursing progress notes revealed no documentation of the incident of verbal abuse by Resident #60.Social service notes, dated 4/7/26 and 4/10/26, indicated Resident #65 said she did not feel unsafe or fearful, but she was frustrated and said, I just stay away from her. On 4/15/26 social services documented Resident #65 again stated she was not fearful and said, I just don't want her to bump into me. III. Additional resident interviewsResident #49 was interviewed on 4/28/26 at 2:55 p.m. Resident #49 said he had heard and witnessed on several occasions Resident #60 calling Resident #65 names and making mean hand gestures towards her. He said this happened in the dining room. Resident #59 was interviewed on 4/28/26 at 4:15 p.m. Resident #59 said she had witnessed on several occasions where Resident #60 called Resident #65 names, such as fat (expletive) in the dining room. IV. Staff InterviewsThe NHA was interviewed on 4/30/26 at 9:00 a.m. The NHA said during Resident #65's care conference on 4/7/26 the resident's representative mentioned the verbal abuse from Resident #60 and Resident #65 verified it. She said the resident's representative and the resident did not indicate when the verbal abuse occurred. The NHA said an abuse investigation was started on 4/7/26.The social services director (SSD) was interviewed on 4/30/26 at 9:09 a.m. The SSD said on 4/7/26 during Resident #65's care conference, the resident's representative said that the resident had mentioned verbal abuse from Resident #60 and Resident #65 verified it, but they did not indicate when it happened. She said after the allegation, the social services department followed up with both residents several times and neither resident was fearful of the other. She said she did not know why the care plans had not been updated to reflect the incident. Certified nurse aide with medication authority (CNA-Med) #1 was interviewed on 4/30/26 at 11:35 a.m. CNA-Med #1 said she had heard Resident #65 complain many times about Resident #60 calling her names and being mean to people in the dining room, but she was uncertain when the incidents occurred. The activity assistant (AA) was interviewed on 4/30/26 at 12:05 p.m. The AA said she had witnessed Resident #60 intentionally running into Resident #65's wheelchair on numerous occasions and calling her names in the dining room. She said she had witnessed Resident #60 being verbally aggressive to male residents in the dining room as well. She said she had reported these incidents to management.Certified nurse aide (CNA) #2 was interviewed on 4/30/26 at 12:40 p.m. CNA #2 said she witnessed the verbal abuse incident a few weeks ago between Resident #60 and Resident #65. She said Resident #60 called Resident #65 a fat (expletive). She said she reported it to management and encouraged Resident #65 to report it as well. The NHA and the regional clinical resource were interviewed together on 4/30/26 at 2:30 p.m. The NHA said based on the facility's investigation of the incident, she did not substantiate the verbal abuse of Resident #65 by Resident #60 because she felt it did not meet the criteria. She said when Resident #65 was initially interviewed, she indicated she was not fearful of Resident #60. The NHA said follow-up with Resident #65 after 4/7/26 continued to indicate she was not fearful and the two residents did not interact. -However, abuse occurred due to Resident #60 making willful verbal insults to Resident #65 causing significant emotional distress for Resident #65 (see resident's interview above). The regional clinical resource said Resident #60 had moved to a different hall in the facility because of prior disagreements with Resident #65 and there had been no further allegations of verbal abuse.

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	065165	A. Building B. Wing	04/30/2026

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F 0695 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide safe and appropriate respiratory care for a resident when needed. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observations, record review and interviews, the facility failed to provide necessary respiratory care and services consistent with professional standards of practice and the comprehensive person-centered care plan for two (#89 and #65) of three residents reviewed for respiratory care out of 51 sample residents. Specifically, the facility failed to:-Ensure that Resident #89 received oxygen therapy in accordance with his physician's orders; and,-Ensure Resident #65's BIPAP (bilevel positive airway pressure, a non-invasive ventilator used to treat breathing difficulties) equipment was maintained in a sanitary manner in accordance with physician's orders.Findings include: I. Professional reference According to Nursing Skills, Open Resources for Nursing (Open RN), Ernstmeyer K, [NAME] E, editors. Eau [NAME] (WI): [NAME] Valley Technical College; published 11/11/21, accessed on 5/4/26 from https://www.ncbi.nlm.nih.gov/books/NBK593208/, Oxygen is considered a medication and, therefore, requires a prescription and continuous monitoring by the nurse to ensure its safe and effective use. (Chapter 11) Devices such as high flow oximetry masks, CPAP (continuous positive airway pressure, BIPAP or mechanical ventilation may be initiated by the respiratory therapist or provider to deliver higher amounts of inspired oxygen (Chapter 11) Manage oxygen therapy and equipment: If the patient is already on supplemental oxygen, ensure the equipment is turned on, set at the required flow rate, correctly positioned on the patient, and properly connected to an oxygen supply source. Ensure the connecting oxygen tubing is not kinked, which could obstruct the flow of oxygen. Feel for the flow of oxygen from the exit ports on the oxygen equipment. II. Facility policy and procedure The Oxygen Administration, Storage and Handling policy, revised July 2017, was provided by the nursing home administrator (NHA) on 4/29/26 at 1:10 p.m. It read in pertinent part, It is the policy of this facility to promote resident safety with oxygen administration. The resident's clinical record will include that oxygen is to be administered, when and how often oxygen is to be administered, the type of oxygen device to use, any special procedures or treatment to be administered, charting and documentation related to oxygen use and oxygen concentrators will be maintained in the room when oxygen is ordered. III. Resident #89 A. Resident status Resident #89, age greater than 65, was admitted on [DATE]. According to the April 2026 computerized physician orders (CPO), diagnoses included acute and chronic respiratory failure with hypercapnia (excess of carbon dioxide in the blood due to respiratory failure), pulmonary edema, pneumonia, chronic obstructive pulmonary disease and congestive heart failure. (continued on next page)

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	065165	A. Building B. Wing	04/30/2026

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F 0695 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	The 4/29/26 minimum data set (MDS) assessment identified Resident #89 was cognitively intact with a brief interview for mental status (BIMS) score of 13 out of 15. The MDS assessment revealed the resident required set-up assistance with eating and was dependent upon staff for showering, dressing and transferring. B. Resident observations and interviews On 4/27/26 at 3:40 p.m. Resident #89 was lying in his bed wearing a nasal cannula (a tubing device that delivers oxygen through the nose) in his nose and connected to a room oxygen concentrator. The oxygen concentrator was set to 4 liters per minute (LPM) of oxygen. Resident #89 said the oxygen was usually set to 3 LPM, however, the nursing staff had turned it up to 4 LPM earlier in the day after his physical therapy. On 4/28/26 at 11:30 a.m. Resident #89 was sitting in his bed wearing the nasal cannula. The oxygen concentrator was set to 4 LPM. Resident #89 said the nursing staff had left his oxygen concentrator on 4 LPM since the previous day. On 4/28/26 at 5:49 p.m. Resident #89 was sitting on the side of his bed eating dinner and wearing the nasal cannula. The resident's oxygen concentrator was set to 4 LPM. Resident #89 said the nursing staff had not changed the oxygen flow rate level since it was increased to 4 LPM (on 4/27/26). On 4/29/26 at 8:25 a.m. Resident #89 was sitting on the side of his bed and wearing the nasal cannula. The resident's oxygen concentrator continued to be set to 4 LPM. C. Record review A review of Resident #89's oxygen therapy care plan, initiated 4/17/26, revealed Resident #89 required oxygen for respiratory failure. Interventions included giving the medications and oxygen as ordered by the physician, monitoring for signs and symptoms of respiratory distress and reporting to the physician as needed, which included respirations, pulse oximetry, increased heart rate, restlessness, diaphoresis, headaches, lethargy, confusion, atelectasis, hemoptysis, cough pleuritic pain, accessory muscle usage and skin color. A review of Resident #89's April 2026 CPO revealed the following physician's order: Apply oxygen per nasal cannula at 3 LPM continuously, ordered 4/27/26. -However, Resident #89's oxygen flow rate had been set to 4 LPM since 4/27/26 (see resident interviews/observations above). D. Staff interviews Licensed practical nurse (LPN) #1 was interviewed on 4/29/26 at 9:28 a.m. LPN #1 said Resident #89's oxygen concentrator was set to 4 LPM. LPN #1 said she reviewed the physician's order, and Resident #89's oxygen order was for 3 LPM. LPN #1 said if the resident's oxygen requirement had increased, the physician should have been notified. LPN #1 said she did not see documentation that a physician was notified when Resident #89's oxygen flow rate was increased to 4 LPM. The director of nursing (DON) and the regional clinical resource were interviewed together on 4/29/26 (continued on next page)

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	065165	A. Building B. Wing	04/30/2026

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F 0695 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	at 9:39 a.m. The DON said the nurses should have contacted the physician if Resident #89's oxygen requirement had increased. The DON said it was important to contact the physician when oxygen needs changed, as it was a condition change for the resident. IV. Resident #65 A. Resident status Resident #65, age greater than 65, was admitted on [DATE]. According to the April 2026 CPO, diagnoses included osteoarthritis (chronic joint disease), spinal stenosis, hypertension, major depressive disorder, generalized anxiety disorder and muscle weakness. The 3/11/26 MDS assessment revealed the resident was cognitively intact with a BIMS score of 15 out of 15. She required staff supervision for toileting and transfers, moderate assistance with personal hygiene and set-up assistance with eating. The MDS assessment did not indicate that Resident #65 used a BiPAP machine. B. Observations and resident interviews On 4/27/26 at 10:05 a.m. Resident #65 was sitting in her wheelchair in her room. Resident #65's BiPAP machine was positioned on top of her bedside drawer, next to a gallon of distilled water. The humidifier chamber had a small amount of water in it and condensation was visible on the sides and top of the water chamber. Resident #65 said she cleaned her BiPAP machine by herself every now and then. There was a connecting tube from the BiPAP machine to the mask. The mask was lying across the top of the resident's bedside drawer, with the inside surface of the mask directly touching the top of the bedside drawer. Resident #65 said the BiPAP machine mask had always been sitting on top of her bedside drawer. She said she cleaned it with water and dried it with a paper towel whenever she could. On 4/28/26 at 3:15 p.m. Resident #65 was sitting in her wheelchair facing her bed and her bedside drawer. The BiPAP machine and the tube connecting the machine to the mask were uncovered and lying on top of the resident's bedside drawer. There was visible condensation in the water chamber and the mask was lying uncovered on top of the bedside drawer. Resident #65 said the staff did not clean the BiPAP machine and mask. On 4/29/26 at 8:30 a.m. Resident #65's BiPAP machine was located in the same spot on the resident's bedside dresser. The humidifier's water chamber still had visible condensation and a small amount of water in it. The tube connected to the mask lay uncovered, touching the dresser surface. Resident #65 said the staff did not perform maintenance and cleaning services for her BiPAP machine. Resident #65 said she maintained and performed cleaning of the BiPAP machine whenever she was able to. She said she did not follow a specific schedule. She said she did not know how often to clean her BiPAP machine and was not told to leave the mask to air-dry after cleaning. C. Record review A review of Resident #65's April 2026 CPO revealed the following physician order: (continued on next page)

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	065165	A. Building B. Wing	04/30/2026

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F 0695 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Change distilled water in BiPAP and clean BiPAP mask with soap and water, and let it air dry every night shift for maintenance, ordered 9/5/25. -However, according to interviews with Resident #65, the resident performed maintenance cleaning as needed and dried the BiPAP mask with a paper towel (see resident's interview above). Review of Resident #65's respiratory care plan, initiated 9/5/25, revealed the resident required a BiPAP due to risk for reduced pulmonary ventilation and other respiratory complications secondary to central sleep apnea. -The care plan failed to include the physician's ordered maintenance of the BiPAP machine and the mask. D. Staff interviews Registered nurse (RN) #1 was interviewed on 9/30/26 at 9:15 a.m. RN #1 said there was a physician's order to clean Resident #65's BiPAP mask with soap and water each night and allow it to air-dry. RN #1 said there was no documentation in the resident's electronic medical record (EMR) indicating Resident #65's BiPAP mask was cleaned as ordered. RN #1 said to avoid contamination, it was important to follow the physician's maintenance orders for the resident's BiPAP machine and mask. RN #1 said leaving the mask on high-touch areas, cluttered surfaces, and directly on top of bedside drawers exposed it to dust and bacteria. RN #1 said she would immediately inform the DON about the storage and maintenance concerns for Resident #65's BiPAP mask. The DON and the regional clinical resource were interviewed together on 4/30/26 at 10:45 a.m. The DON said it was important to follow the cleaning and maintenance physician's order for Resident #65's BiPAP machine in order to prevent possible respiratory infections and skin integrity issues. The DON said she was informed by RN #1 about the concerns for Resident #65's BiPAP machine and had taken steps to correct the issue. The DON said the current physician's order for the resident's BiPAP cleaning and maintenance was supposed to be completed by the overnight shift each day, not by Resident #65. The DON said an assessment of the resident should be completed with a licensed nurse if Resident #65 preferred to clean her own BiPAP mask in order to promote her independence and also to ensure she was capable of following the physician's maintenance cleaning order. The regional clinical resource said education would be immediately provided to staff to ensure the physician's orders for all BiPAP machines and respiratory equipment were followed to prevent a respiratory infection outbreak. The regional clinical resource said she did not know why the staff failed to ensure Resident #65's BiPAP mask was stored and cleaned appropriately.

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	065165	A. Building B. Wing	04/30/2026

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Riverbend Health and Rehabilitation Center	821 Duffield CT Loveland, CO 80537

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 0761 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure drugs and biologicals used in the facility are labeled in accordance with currently accepted professional principles; and all drugs and biologicals must be stored in locked compartments, separately locked, compartments for controlled drugs. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observations, record reviews and interviews, the facility failed to ensure proper storage of medications for one of four medication carts and two of three medication storage rooms.Specifically, the facility failed to:-Discard medications that were expired; -Label an inhaler with the date it was opened;-Discard a vial of eye drops for a resident who had been discharged ; and,-Discard undated opened medication tuberculin PPD (purified protein derivative) from a medication storage refrigerator.Findings include:I. Professional referencesAccording to the package insert for Breo Ellipta Inhalation Aerosol Powder Breath Activated 100-25 mcg (micrograms)/act (actuation inhaler, retrieved on [DATE] from https://www.accessdata.fda.gov/drugsatfda_docs/label/2017/204275s012lbl.pdf, Safely throw away Breo Ellipta in the trash six weeks after you open the foil tray or when the counter reads 0, whichever comes first. Write the date you open the tray on the label on the inhaler.According to the manufacturer, Sanofi Pasteur Limited, Product Monograph for Tubersol, [DATE], retrieved on [DATE] from https://www.sanofi.com/assets/countries/canada/docs/products/vaccines/tubersol-en.pdf#:~:text=TUBERSOL%C2%AE A vial of Tubersol which has been entered and in use for 30 days should be discarded.II. Facility policy and procedureThe Medication Access and Storage, E-kit (emergency kit) Access policy, revised [DATE], was provided by the nursing home administrator (NHA) on [DATE] at 5:29 p.m. It read in pertinent part, Outdated, contaminated, or deteriorated medications and those in containers that are cracked, soiled, or without secure closures are immediately removed from stock, disposed of according to procedures for medication destruction and reordered from the pharmacy, if a current order exists. Any vial without an open date will be discarded immediately, and replaced with a new vial. Any medication that can not be verified as to the expiration date, either due to not being dated when opened, or unclear shelf life, shall be discarded immediately and replaced.III. Observations and staff interviews On [DATE] at 2:34 p.m. the front east medication cart was observed with registered nurse (RN) #2. The following medications were found: -A used Breo Ellipta Inhalation Aerosol Powder Breath Activated 100-25 mcg/act inhaler for Resident #1 which was not labeled with the date it was opened.RN #2 said the inhaler should have been labeled with the date it was opened RN #2 said because there was no opened date on the inhaler, the inhaler should have been removed from the cart and given to the director of nursing (DON) for disposal. -A used floor stock bottle of liquid Delsym Pediatric Cough/12-hour medication with an expiration date of [DATE]. RN #2 said the cough medication should have been discarded on the expiration date of [DATE].-A box of floor stock Rugsby Hemorrhoid Suppositories, with nine of twelve suppositories remaining in the box, with an expiration date of [DATE].RN #2 said the box of suppositories should have been discarded on the expiration date of [DATE].On [DATE] at approximately 3:00 p.m. the front office medication storage refrigerator was observed with the DON. The following medication was found:A bottle of Latanoprost eye drops for Resident #104, who was discharged on [DATE]. The DON said the Latanoprost eye drops should have been removed and discarded when the resident was discharged on [DATE].On [DATE] at 3:15 p.m. the vaccine storage refrigerator was observed with the DON. The following medications were found: -Two opened vials of multi-dose Tubersol, tuberculin PPD 5 TU/0.1 ml (milliliters) vaccine solution which were not labeled with the date the vials were opened.The DON said the Tuberculin vials should have been labeled with the date they were opened and should have been discarded after the 30-day period from the date the vials were opened. The DON said Tuberculin vaccine that was used out of the acceptable date range could be less effective.