STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	065283	A. Building B. Wing	04/08/2026

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Ridgeview Post Acute	5230 E 66th Way Commerce City, CO 80022

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. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on record review and interviews, the facility failed to ensure one (#3) of four residents reviewed out of 16 sample residents was kept free from resident-to resident physical abuse.Specifically, the facility failed to protect Resident #3 from physical abuse by Resident #4.Findings include:Record review and interviews confirmed the facility corrected the deficient practice prior to the onsite investigation on 4/6/26 to 4/8/26, resulting in the deficiency being cited as past noncompliance with a correction date of 3/25/26.I. Incident of physical abuse by Resident #4 toward Resident #3 on 1/19/26On 1/19/26 at 5:00 a.m. certified nurse aide (CNA) #3 heard activity from the room shared by Resident #3 and Resident #4. When CNA #3 entered the residents' room, she observed Resident #4 was standing near Resident #3's bed and was attempting to remove a pillow from beneath Resident #3's head. CNA #3 separated the residents and assisted Resident #4 to her side of the room. Approximately 20 minutes later, CNA #3 saw Resident #4 take a pillow from her own bed and go to Resident #3 and Resident #4 hit Resident #3 three times with the pillow. Resident #3 was upset and was screaming get her away from me! CNA #3 intervened and redirected Resident #4. II. Facility action to correct the deficient practiceThe facility moved Resident #3 to a different room on 1/19/26 and Resident #4 was no longer assigned a roommate.Resident #4 continued with one-to-one supervision during waking hours and did not have any additional roommates after the incident between her and Resident #3.The facility implemented a new process after the 1/19/26 incident, which included staff obtaining and completing an abuse packet immediately after an incident.The facility discussed the 1/19/26 physical abuse incident between Resident #4 and Resident #3 in the facility's monthly quality assurance performance improvement (QAPI) meeting.-However, on 3/22/26, Resident #4 had an encounter with another resident where Resident #4 held onto another resident's arm lightly for a few seconds and then let go. The facility did not substantiate the encounter as abuse, however the encounter prompted the facility to provide further abuse education with staff (see below). On 3/24/26, the assistant director of nursing (ADON) provided education regarding redirecting residents using snacks and activitiesThe education included information about why redirection works, redirection instructions, helpful phrases to use, reminders and specific interventions for Resident #4, including offering snacks that she preferred, such as chocolate pudding and oatmeal cookies, redirection to her room and resident preferences for specific games. The education was only signed by 15 nursing staff members.However, on 3/25/26, the clinical resource nurse provided further in-depth education to all staff regarding abuse prevention and management. The education included definitions of abuse, tips for preventing abuse and who staff should report allegations of abuse to. The education was signed by 52 staff members from all disciplines.III. Facility policy and procedureThe Abuse Prevention and Reporting policy, revised June 2025, was provided by the nursing home administrator (NHA) on 4/7/26 at 2:32 p.m. It read in pertinent part, It is the policy of this facility that residents will be free from verbal abuse, physical abuse, mental abuse, sexual abuse, involuntary seclusion, neglect and exploitation. Residents will not be subjected to abuse by anyone, including but not limited to facility staff, other residents, consultants, volunteers, staff or other agencies serving the residents, family (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 0600 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	members or legal guardians, friends or other individuals. All allegations of abuse are investigated. Any staff member who has reasonable cause to believe or reason to suspect any situation that may be considered abuse will immediately report to the charge nurse. The staff member will intervene and ensure that the resident is safe. Make sure that all residents are kept safe during the investigation. If a resident is the assailant, make sure that they are kept out of the reach of other residents and increase monitoring of the assailant.IV. Facility investigation of the abuse incident between Resident #4 and Resident #3 on 1/19/26The facility's abuse investigation was provided by the NHA on 4/7/26 at 9:00 a.m.The facility documented the date of the incident as 1/19/26 at 5:00 a.m.The facility investigation documented CNA #3 heard activity from the room shared by Resident #3 and Resident #4. It documented when CNA #3 entered the room, she observed Resident #4 was standing near Resident #3's bed and was attempting to remove a pillow from beneath Resident #3's head. It documented Resident #4 then picked up a pillow and made contact with Resident #3 with the pillow. It documented CNA #3 intervened and redirected Resident #4.The facility's investigation concluded that there was a verbal exchange between Resident #3 and Resident #4 and Resident #4 used a pillow and made contact with Resident #3. It documented information that was obtained through interviews, chart review and assessments did not result with any significant findings. -However, a witness interview revealed Resident #3 was upset after the incident (see interview below) and Resident #3 was moved to a different room.V. Resident #4 (assailant)A. Resident statusResident #4, age [AGE], was admitted on [DATE]. According to the April 2026 computerized physician orders (CPO), diagnoses included dementia, insomnia, chronic obstructive pulmonary disease (COPD - a lung disease) and depression.The 3/7/26 minimum data set (MDS) assessment identified Resident #4 had moderate cognitive impairment with a brief interview for mental status (BIMS) score of nine out of 15. Resident #4 required set-up assistance with eating, was able to transfer herself independently and required substantial assistance with dressing and showering.The MDS assessment identified Resident #4 had wandering behavior one to three days per week. B.Observation and interviewOn 4/6/26 at 10:15 a.m. Resident #4 was in her room. The resident had no roommate and had a CNA in her room providing one-to-one observation and assistance for the resident. The CNA was sitting in the corner of the room and Resident #4 was sitting up in her bed and was anxious, rocking back and forth. Resident #4 said her previous roommate made a lot of noise. Resident #4 said she did not remember any incidents with other residents, including her previous roommate, at the facility.C. Record reviewResident #4's potential for behavior problem verbal/physical aggression related to dementia diagnosis care plan, revised 4/6/26, revealed Resident #4 had a history of being physically aggressive towards others, a history of saying she would kill staff and would make repetitive statements, such as I hate you and I hate living here. The care plan documented Resident #4 perseverated on various topics that made her upset, even if they had been addressed and resolved. The care plan documented Resident #4 had a history of being verbally rude to others around her, had thrown food, drinks and markers at other residents, had pulled the hair bow of another resident and had thrown and hit others with pillows. The care plan documented triggers for Resident #4 included touching her items, crowds, strangers or doing something from behind her. Pertinent care plan interventions included ensuring Resident #4's hearing aids and glasses were used when needed, having the resident's room located next to the nurses' station, providing activities of interest, anticipating and meeting the resident's needs, encouraging the resident to express feelings appropriately, decreasing interactions with other residents as able, keeping her at arm's length from others when able, providing distraction and redirection as needed, educating family/caregivers on successful coping and interaction strategies, encouraging more days at her senior day care offsite facility and providing one-to-one observation with staff during waking hours.A nursing progress note, dated 1/19/26 at 1:46 p.m., documented the nurse was notified by a CNA that Resident #4 was witnessed throwing a pillow towards her roommate (Resident #3). The note documented the pillow made contact with Resident #3 before the CNA could intervene. The note documented the CNA (continued on next page)

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F 0600 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	separated the residents. The note documented Resident #4 was not interviewable after the incident due to her cognition.VI. Resident #3 (victim)A. Resident statusResident #3, age [AGE], was admitted on [DATE] and discharged on 1/29/26. According to the January 2026 CPO, diagnoses included dementia, COPD, stroke and kidney disease.The 1/1/26 MDS assessment revealed the facility was unable to complete a BIMS assessment for Resident #3. The MDS assessment revealed Resident #3 required set-up assistance with eating and required substantial assistance with dressing, showering and transferring.The MDS assessment identified Resident #3 had no behavior symptoms directed toward others. B. Record reviewResident #3's potential behavioral problem, paranoia, accusatory behavior related to dementia and history of stroke, initiated 5/22/25, revealed Resident #3 at times yelled out about people on the television watching her and/or her friends, called out that she was naked when she was not and said water was cold when it was at normal temperatures. Pertinent interventions included medications as ordered with monitoring for side effects, anticipating need, approaching in a calm manner, redirecting the resident away from television when distressing to the resident, discussing behavior if reasonable, explaining and reinforcing why it was inappropriate and intervening as necessary to protect the rights and safety of others, removing the resident from the situation and taking resident to alternative location as necessary.A nursing progress note, dated 1/19/26 at 6:00 a.m., documented Resident #3 was a recipient of a physically aggressive behavior from her roommate. The note documented Resident #4 walked toward Resident #3, who was lying supine in bed. It documented Resident #4 made physical contact with Resident #3 three times before being separated by staff. It documented the incident had begun with a verbal exchange between the roommates. It documented Resident #3 said she was hit several times by her roommate for no reason and she did not hit back. The nursing note documented Resident #3 denied pain or discomfort as a result of the physical aggression by Resident #4. It documented that Resident #3 did not want to be in the same room with Resident #4 and therefore Resident #3 was moved to another room.A social services progress note, dated 1/19/26 at 1:00 p.m., documented Resident #3's representative was notified regarding the incident between Resident #4 and Resident #3. The representative was advised of Resident #3's room change, which occurred on the same day of the incident. VII. Staff interviewsCNA #3 was interviewed on 4/8/26 at 10:40 a.m. CNA #3 said she heard Resident #3 and Resident #4 arguing. She said she went into the residents' room and saw Resident #4 was standing next to Resident #3's bed and was trying to take Resident #3's pillow from under her head. CNA #3 said she separated the residents and assisted Resident #4 to her side of the room. CNA #3 said about 20 minutes later she saw Resident #4 take a pillow from her own bed and go to Resident #3 and Resident #4 hit Resident #3 three times with the pillow. CNA #3 said she removed Resident #4 from the room in her wheelchair. CNA #3 said that Resident #3 was upset and was screaming get her away from me! The NHA, the director of nursing (DON) and the clinical resource nurse were interviewed together on 4/8/26 at 2:09 p.m. The NHA said Resident #4 had been without a roommate for a long time. The NHA said Resident #4 had previously had incidents with other residents so the facility had given her a room by herself. He said the resident had not had any incidents with other residents for at least seven months (prior to the incident with Resident #3), so the facility developed a plan to determine if Resident #4 could transition back to having a roommate. The NHA said the situation with Resident #3 had been working out well and Resident #3 and Resident #4 shared a staff member who remained with them during the day, however, he said the incident 1/19/26 happened at night when the residents' room was in view of the nurses' station (directly across the hallway). The NHA said CNA #3 saw Resident #4 attempt to remove Resident #3's pillow from underneath her head. He said CNA #3 separated her from Resident #3 and then Resident #4 later hit Resident #3 with Resident #4's pillow. The NHA said CNA #3 then separated the residents and escorted Resident #4 from the room. The NHA said Resident #3 was not fearful, but was moved to another room as she did not want Resident #4 as a roommate any longer. The NHA said that Resident #3's television was on and he thought that was the reason Resident #4 went over to Resident #3. The DON said if someone destroyed another (continued on next page)

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F 0600 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	resident's peace early in the morning, he could see why the person whose peace was disrupted would be upset. The clinical resource nurse said the witness statement provided during an interview with CNA #3 was not signed by CNA #3 to confirm that she agreed with the statement. The NHA and the clinical resource nurse said they planned to ensure that witness interview statements were signed in the future. The DON said the facility had a new process which began after the 1/19/26 incident between Resident #3 and Resident #4 and included staff obtaining an abuse packet immediately after an incident. The DON said he was working with the nursing team on the process to ensure the staff members would write a statement when the incident occurred. The NHA said it made sense that Resident #3 would be upset after the incident and he said he guessed that she was upset and concerned about it at the time and this was why she was moved out of the room quickly.The NHA said multiple interventions were put into place for Resident #4 to prevent further incidents. The NHA said Resident #4 had not had a roommate since the incident between her and Resident #3. The NHA said the facility had arranged with Resident #4's representative for her to reinitiate an adult day care program which Resident #4 had attended. The NHA said the nursing and CNA staff received reeducation for abuse and dementia care. The NHA said every abuse incident investigation was discussed in the facility's quality assurance performance improvement (QAPI) meetings each month and a meeting had included the incident between Resident #4 and Resident #3.

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F 0609 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Timely report suspected abuse, neglect, or theft and report the results of the investigation to proper authorities. Based on record review and interviews, the facility failed to report allegations of abuse to the State Survey and Certification Agency in accordance with state law for four of four allegations of abuse.Specifically, the facility failed to:-Report an allegation of physical abuse between Resident #1 and Resident #2 on 11/18/25 within two hours of the incident; .-Report an allegation of physical abuse between Resident #3 and Resident #4 on 1/19/26 within two hours of the incident;-Report an allegation of physical abuse between Resident #5 and Resident #6 on 2/8/26 within two hours of the incident; and,-Report an allegation of physical abuse between Resident #4 and Resident #11 on 3/22/26 within two hours of the incident.Findings include:I. Facility policy and procedureThe Abuse Prevention and Reporting policy, revised June 2025, was provided by the nursing home administrator (NHA) on 4/7/26 at 2:32 p.m. It read in pertinent part, The administrator/designee will complete the initial report to the state survey and certification agency within 24 hours electronically via the occurrence reporting portal and complete the report within five days from the initial report.-However, the facility was required to report any abuse allegations within two hours of the incident.II. Record reviewThe facility investigations for four physical abuse allegations were provided by the NHA on 4/7/26 at 9:00 a.m. The investigations documented the following:The alleged physical abuse between Resident #1 and Resident #2 occurred on 11/18/25 at 8:20 a.m. -However, the facility reported the alleged abuse on 11/19/25 at 10:22 a.m., 26 hours after the incident occurred.The alleged physical abuse between Resident #3 and Resident #4 occurred on 1/19/26 at 5:00 a.m. -However, the facility reported the alleged abuse on 1/19/26 at 7:07 p.m., 14 hours after the incident occurred.The alleged physical abuse between Resident #5 and Resident # 6 occurred on 2/8/26 at 8:30 a.m. -However, the facility reported the alleged abuse on 2/8/26 at 9:40 p.m., 13 hours after the incident occurred.The alleged physical abuse between Resident #4 and Resident #11 occurred on 3/22/26 at 11:59 a.m. -However, the facility reported the alleged abuse on 3/23/26 at 11:56 a.m., 24 hours after the incident occurred.III. Staff interviewsThe NHA, the director of nursing (DON) and the clinical resource nurse were interviewed together on 4/8/26 at 2:09 p.m. The NHA said he thought the two hour rule for reporting abuse allegations applied only to those allegations which resulted in serious bodily harm. The NHA said he was provided guidance by a consultant on 4/7/26 that physical abuse allegations had to be reported within two hours. The NHA said he would look at the facility's policy and change the policy accordingly if it did not align with the guidance that was provided to him. The clinical resource nurse said she showed the NHA the occurrence reporting manual. The clinical resource nurse said the facility missed the two hour reporting guidelines for the four physical abuse allegations.