STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	065378	A. Building B. Wing	12/01/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Riverdale Post Acute	2311 E Bridge St Brighton, CO 80601

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 - Some	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 seven (#16, #17, #19, #8, #4, #18 and #11) of 17 residents reviewed for abuse out of 18 sample residents were kept free from abuse.Specifically, the facility failed to:-Ensure Resident #16 and Resident #17 were kept free from physical abuse toward each other on 6/7/25;-Ensure Resident #17 was kept free from physical abuse by Resident #19 on 7/29/25;-Ensure Resident #8 was kept free from physical abuse by Resident #17 on 8/14/25;-Ensure Resident #17 was kept free from physical abuse by Resident #19 on 8/31/25;-Ensure Resident #19 and Resident #17 were kept free from physical abuse toward each other on 9/17/25;-Ensure Resident #4 was kept free from physical abuse by Resident #5 on 6/18/25;-Ensure Resident #18 was kept free from physical abuse by Resident #5 on 8/10/25; and,-Ensure Resident #11 was kept free from physical abuse by Resident #12 on 7/9/25.Findings include:I. Facility policy and procedureThe Abuse, Neglect, Exploitation and Misappropriation Prevention policy, revised 4/1/25, was provided by the nursing home administrator (NHA) on 10/2/25 at 3:57 p.m. The policy read in pertinent part, Residents have the right to be free from abuse, neglect, misappropriation of resident property and exploitation. This includes but was not limited to freedom from corporal punishment, involuntary seclusion, verbal, mental, sexual or physical abuse, and physical or chemical restraint not required to treat the resident's symptoms. The resident abuse, neglect and exploitation prevention program consists of a facility-wide commitment and resource allocation to support the following objectives: Protect residents from abuse, neglect, exploitation or misappropriation of property by anyone including, but not necessarily limited to: facility staff, other residents, friends, any other individuals, legal representatives and visitors. Develop and Implement policies and protocols to prevent and identify abuse or mistreatment of residence. Ensure adequate staffing and oversight to prevent burnout, stress working situations and high turnover rates. Identify and investigate all possible incidents of abuse, neglect, mistreatment or misappropriation of Resident property.I. Incidents of physical abuse involving Resident #17A. Incident of physical abuse between Resident #16 and Resident #17 on 6/7/251. Facility investigationThe facility investigation, dated 6/7/25, was provided by the nursing home administrator (NHA) on 9/30/25 at 4:30 p.m. The investigation revealed the following:On 6/7/25 Resident #17 wandered into Resident #16's room, at which point the residents began arguing with each other. Resident #17 struck Resident #16 in the chest. Resident #16 then threw his coffee cup at Resident #17 which struck him in the face. The residents were separated and placed on frequent checks. Staff were educated to watch for wandering from Resident #17. Both residents were assessed for a change in condition and for any injuries. Residents from the unit were interviewed to see if there were any unreported incidents which needed to be reported. Staff on the unit were interviewed to see if there was any additional information regarding the incident.The investigation indicated Resident #17 had a history of physical and verbal aggression to other residents and staff. Resident #17's care plan documented interventions including providing positive interactions and attention, monitoring medication, providing staff intervention when aggression was initiated and keeping the resident within line of sight as much as possible. The (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 - Some	investigation indicated Resident #16 did not have a history of behaviors and had not been involved in any other incidents in the 12 months prior.The facility concluded the allegation of physical abuse was unsubstantiated since the incident of aggression occurred between both residents.-However, physical abuse occurred due to Resident #17 hitting Resident #16 in the chest and Resident #16 throwing a coffee cup at Resident #17's face.2. Resident #17a. Resident statusResident #17, age [AGE], was admitted on [DATE]. According to the September 2025 computerizedphysician orders (CPO), diagnoses included dementia with behavioral disturbance, adult failure to thrive and senile degeneration of the brain.The 8/29/25 minimum data set (MDS) assessment revealed the resident had moderate cognitive impairment with a brief interview for mental status (BIMS) score of nine out of 15. The resident needed substantial assistance to dependence on staff for most activities of daily living (ADL).The MDS assessment documented the resident did not have physical or verbal behaviors directedat others or other behavioral symptoms not directed toward others during the assessment period.b. Record reviewThe antipsychotic care plan, revised 6/14/22, revealed Resident #17 was at risk for complications related to using antipsychotic medications to treat his insomnia and dementia with behavioral disturbance. Pertinent interventions included reviewing behaviors and interventions and their effectiveness, keeping the resident in the nursing staff's line of sight, and encouraging the resident to stay clear of doorways.The behavior care plan, revised 4/9/24, revealed Resident #17 had a behavior problem which included the resident becoming aggressive toward peers and staff due to his dementia with behavioral disturbance. Resident #17's triggers included reacting to how others were speaking to or about him and reacting when approached or touched from the back or side. Pertinent interventions included frequent checks; providing opportunities for positive reaction; scratching the resident's back and calling him gorgeous; offering snacks and fluids and ensuring the resident sat with his back against the wall.The physical aggression care plan, revised 7/27/23, revealed Resident #17 had the potential to be physically aggressive towards others due to his poor safety awareness and impulse control. Resident #17's triggers included his peers walking up behind him and vulgar language. Resident #17's behaviors were de-escalated by sitting him with his back against the wall and offering him fluids and snacks of his liking. Pertinent interventions included analyzing the time of day, places, circumstances and triggers of an incident; and documenting, assessing and anticipating Resident #17's needs.-The most recent intervention added to Resident #17's care plan was on 1/14/25 related to his exit-seeking behaviors.A progress note, dated 5/25/25 at 10:06 a.m., revealed Resident #17 was being monitored for a decrease in Zyprexa (an antipsychotic medication primarily used to treat schizophrenia and bipolar disorder) dosage. The note documented Resident #17 did not have any change in behaviors. Resident #17 continued to try to leave the building and was kicking and pounding on the exit doors.A progress note, dated 6/13/25 at 5:28 p.m., revealed Resident #17 grabbed another resident (Resident #19) by the arm and pulled. Resident #17 and Resident #19 were immediately separated. The residents were assessed and did not sustain any injuries. The residents' representatives, the DON, the NHA and the residents' physicians were notified.c. Resident #17's representative interviewResident #17's representative was interviewed on 9/30/25 at 12:12 p.m. The resident's representative said Resident #17 had lived at several facilities over the past few years, and the current facility was the only facility that would take Resident #17 due to his behavioral and medical concerns. The resident's representative said he was notified whenever Resident #17 had any incidents with any other residents. He said Resident #17 had issues dealing with his dementia and general decline. The resident's representative said Resident #17 was previously receiving hospice care and without the additional support of the hospice staff, it seemed Resident #17's level of required care was beyond what the facility could provide with their staffing. The resident's representative said Resident #17 had a previous traumatic brain injury which resulted in the resident having impulse control issues. The resident's representative said he and the facility tried to manage Resident #17's conditions with behavioral medications. The resident's representative said Resident #17's issues with impulsivity made him hard to control, as he did not have any (continued on next page)

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F 0600 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	any physical or emotional harm from the event.-However, physical abuse occurred due to Resident #19 tipping Resident #17 out of his wheelchair, resulting in a fall.2. Resident #19a. Resident statusResident #19, age [AGE], was admitted on [DATE]. According to the August 2025 CPO, diagnoses included dementia with behavioral disturbance.The 7/23/25 MDS assessment revealed the resident had severe cognitive impaired with a BIMS score of zero out of 15. The resident required supervision to substantial assistance for all ADLs.The MDS assessment documented the resident had physical and verbal behaviors directedat others on one to three days of the seven day assessment period.b. Resident representative interviewResident #19's representative was interviewed on 9/30/25 at 1:35 p.m. The resident's representative said she felt the facility was not well staffed and she did not think there were enough staff members to supervise the residents on the secured unit. She said Resident #19 had previously had issues with other residents. The resident's representative said there had been a lot of resident-to- resident incidents involving Resident #19 in the last few months She said she felt the incidents happened because there were not enough staff members in the secured unit and the staff members did not watch Resident #19 as much as they used to. The resident's representative said she was aware another resident hit Resident #19 recently. The resident's representative said Resident #19 was very private and tended to become very upset when other residents walked into his room, which had been an issue in the past. c. Record reviewThe behavioral care plan, revised 8/8/25, revealed Resident #19 had a history of physical and verbal aggression towards staff. Pertinent interventions included administering medications as ordered, assessing and anticipating the resident's needs, performing frequent checks, analyzing the resident's triggers, determining what de-escalated the resident and documenting the findings.-The behavioral care plan did not document the resident's identified trigger of physical aggression when other residents entered his room (see above interview with the resident's representative).The antipsychotic medication care plan, revised 8/5/24, revealed Resident #19 received an antipsychotic medication for behavioral management due to his potential for injury to himself or others, as he had a history of choking a staff member at a previous facility. Interventions included administering medications as ordered, monitoring for target behaviors, and psychiatry to review medications after a recent physical altercation (initiated 9/2/25).C. Incident of physical abuse between Resident #8 and Resident #17 on 8/14/251. Facility investigationThe facility investigation, dated 8/15/25, was provided by the NHA on 9/30/25 at 4:30 p.m. The investigation revealed the following:On 8/14/25 at 2:25 p.m. Resident #8 was wandering through the hall and ran into Resident #17's wheelchair. Resident #17 reacted and hit Resident #8 in the face. The incident was witnessed by a member of the nursing staff. The residents were separated, assessed and put on frequent checks. The investigation indicated Resident #17 had a history of physical and verbal aggression toward other residents and staff. Resident #17's care plan documented interventions including providing positive interactions and attention, monitoring medication, providing staff intervention when aggression was initiated, and keeping the resident within line of sight as much as possible. The investigation indicated Resident #8 had a history of behaviors, including throwing objects when he was upset and initiating aggression towards another resident. The resident had not been involved in any other incidents in the 12 months prior. Resident #8's care plan included interventions such as anticipating the resident's needs, providing quiet areas for him to calm down, and to be non-confrontational when approaching him.The facility concluded the allegation of physical abuse was unsubstantiated since the incident between Resident #8 and Resident #17 did not result in any physical or emotional harm.-However, physical abuse occurred due to Resident #17 hitting Resident #8 in the face.The facility follow-up actions included reviewing both residents' care plans for potential additions, and reviewing the incident in their IDT team meeting to see what potential interventions could be used. -However, Resident #17's care plan was not updated following this resident-to-resident altercation.2. Resident #8a. Resident statusResident #8, age less than 65, was admitted on [DATE]. According to the August 2025 CPO, diagnoses included dementia with behavioral disturbance, impulse disorder and depression.The 6/18/25 MDS assessment revealed (continued on next page)

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F 0600 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	staff notified the physician and the resident's responsible party, and documented their follow-up and monitoring of the resident for the next 72 hours. The DON said the nursing staff documented if the resident voiced any fear, new details or had any changes in mentation or behaviors. The DON said a skin assessment was performed if new skin changes were noted. The DON said the nursing staff performed behavior monitoring to watch for any tearfulness, frustration, or other behaviors outside the resident's normal demeanor. The DON said this was documented in the resident's progress notes. The DON said every risk management assessment was reviewed by the IDT team, during which time the residents' care plans were reviewed and new interventions added as needed. The DON said the residents' previous interventions were assessed to determine effectiveness and removed any ineffective interventions. The DON said assessments and care plan updates were important to perform so the facility staff members would know how to effectively care for the residents in the facility.The DON said the IDT examined the root cause of the incidents to determine why the resident-to-resident incident occurred, and assessed for interventions to put into place to prevent further incidents. The DON said this analysis was completed during every abuse investigation.The NHA, the SSD and the DON were interviewed together again on 10/1/25 at 5:14 p.m. The NHA said Resident #17 was a former prison guard and was very reactionary.The SSD said the staff's interventions to calm Resident #17 included distracting him with movies, his television, taking him for a walk and talking about his son or his past. The SSD said Resident #17 did not like to be approached from behind. The SSD said Resident #17 was very social. The NHA said the facility was struggling to find different effective interventions for Resident #17. The SSD said Resident #17 struggled in group activities and was placed on a one-to-one activity program. The SSD said the facility had tried different medication adjustments for Resident #17 as wellThe DON said Resident #17's care plan was updated to include his triggers. The DON said she thought this was done recently, but upon review of Resident #17's care plan she said it was not completed. The SSD said keeping Resident #17 within line of sight, having a staff member in the dining room with him whenever he was there, keeping him occupied, or setting the resident up in his room were recent interventions that were added to his plan of care. The NHA said Resident #17's room was right next to the nurses' station. The NHA said he did not know if there were any specific interventions to help prevent Resident #17 from reacting to someone walking up behind him, which was why the facility moved his room to the nurses' station so the staff could keep an eye on him and intervene.The SSD said during the one-to-one activity program, the activities staff tried to take Resident #17off the unit as much as possible and take him to group activities.The DON said a specific person at the facility was not assigned to add care plan interventions. The DON said a staff member took notes during their IDT meetings and someone else added the care plan interventions afterwards. The DON said her goal was to put in a new intervention into the residents' care plans after each incident.The NHA said the facility staff had made updating the residents' care plans after each incident a goal, but their documentation was not there. The NHA said he, the DON and the SSD should be responsible for ensuring the residents' care plans were updated after each incident.II. Incidents of physical abuse involving Resident #5A. Incident of physical abuse of Resident #4 by Resident #5 on 6/18/251. Facility investigationThe facility investigation, dated 6/19/25, was provided by the NHA on 9/30/25 at 3:20 p.m. The investigation revealed the following:On 6/18/25 at 6:00 p.m. during a scheduled smoking time, Resident #4 was upset with another resident when Resident #5 approached her and scratched her arm. The residents were separated, assessed and put on frequent checks. Resident #4 sustained scratch marks down both forearms.The investigation documented Resident #4 had a history of behaviors, including self-destructive behaviors and a history of not taking her medications or eating meals. The behavioral care plan included interventions such as reminding the resident to choose positive behaviors and encouraging the resident to take her medications. Resident #4 had not been involved in any other incidents in the previous 12 months.The investigation documented Resident #5 did not have a history of behaviors, and did not indicate if Resident #5 had been involved in any other incidents in the (continued on next page)

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	065378	A. Building B. Wing	12/01/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Riverdale Post Acute	2311 E Bridge St Brighton, CO 80601

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F 0600 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	previous 12 months.-However, Resident #5 had been involved in a physical altercation two months prior to the 6/18/25 incident with Resident #4.The facility substantiated physical abuse as contact was made from the assailant to the vi

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F 0609 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Timely report suspected abuse, neglect, or theft and report the results of the investigation to proper authorities. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on record review and interviews, the facility failed to report alleged violations of physical abuse to the State Survey and Certification Agency in accordance with state law for two (#6 and #17) of 17 residents reviewed for abuse out of 18 sample residents.Specifically, the facility failed to ensure incidents of alleged physical abuse involving Resident #6 and Resident #17 were reported to the State Survey Agency (SSA). Findings include: I. Facility policy and procedure The Abuse, Neglect, Exploitation or Misappropriation Reporting and Investigating policy and procedure, dated September 2022, was provided by the nursing home administrator (NHA) on 10/1/25 at 6:31 p.m. It read in pertinent part, All reports of resident abuse (including injuries of unknown origin), neglect, exploitation, or theft/misappropriation of resident property are reported to local, state and federal agencies (as required by current regulations) and thoroughly investigated by facility management. Findings of all investigations are documented and reported. Policy interpretation and implementation: If resident abuse, neglect, exploitation, misappropriation of resident property or injury of unknown source is suspected, the suspicion must be reported immediately to the administrator and to other officials according to state law. The administrator or the individual making the allegation immediately reports his or her suspicion to the following persons or agencies: The state licensing/certification agency responsible for surveying/licensing the facility; The local/state ombudsman; The resident's representative; adult protective services (where state law provides jurisdiction in long-term care); law enforcement officials; the resident's attending physician; and the facility medical director. All allegations are thoroughly investigated. The administrator initiates investigations. II. Resident #6 A. Allegation of abuse on 9/9/25 between Resident #6 and Resident #21 The facility abuse investigation was provided by the NHA on 9/30/25 at 3:45 p.m. The abuse investigation included an interview with Resident #21, dated 9/10/25, completed by social services assistant #1. The interview documented Resident #6 got mad at Resident #21 (who was his roommate) for leaving the bathroom door open. He said both he and Resident #6 were lying in bed, awake. He said Resident #6 began yelling and threatened to punch him in the face. Resident #21 said certified nurse aide (CNA) #2 entered the room just as Resident #6 was getting ready to throw the rolling bedside table at him. Resident #21 said he witnessed verbal aggression between residents every day. The 9/9/25 nursing progress note, documented at 6:30 a.m., revealed the nurse heard yelling coming from Resident #6 and Resident #21's room. When the nurse entered the room, the nurse witnessed Resident #21 sitting quietly on the side of his bed while his roommate (Resident #6) was yelling at him. Two CNAs were standing in front of Resident #6. The nurse immediately removed the resident (continued on next page)

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F 0609 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	from the room into the dining room. An assessment was completed with no injuries noted and the resident denied pain. The incident was under investigation. The 9/9/25 change of condition form for Resident #6 revealed behavioral changes with physical aggression. The behavioral changes were documented as yelling at his roommate, throwing things, pushing the resident's end table into Resident #21, which hit Resident #21's right arm. Resident #6 continued to be agitated after the incident and was provided a quiet environment. The 9/10/25 interdisciplinary team (IDT) behavior note revealed that on 9/9/25 at 6:30 a.m., Resident #6 had thrown several items on the floor and was yelling at Resident #21. Resident #6 had pushed the bedside table at Resident #21. The NHA, the physician and the resident's guardian were notified. -The facility was unable to provide documentation the allegation of abuse was reported to the SSA. B. Staff interviews The NHA, the director of nursing (DON), and the social services director (SSD) were interviewed together on 10/1/25 at 4:06 p.m. The NHA said he was responsible for reporting allegations of abuse to the SSA. The NHA said the allegation of physical abuse on 9/9/25 between Resident #6 and Resident #21 was not reported to him and therefore was not reported to the SSA. -However, the change of condition assessment documented the NHA was notified of the incident between Resident #6 and Resident #21. The NHA said all allegations of abuse should be reported to the SSA. III. Resident #17 A. Resident status Resident #17, age [AGE], was admitted on [DATE]. According to the September 2025 computerized physician orders (CPO), diagnoses included dementia with behavioral disturbance, adult failure to thrive and senile degeneration of the brain. The 8/29/25 minimum data set (MDS) assessment revealed the resident had moderate cognitive impairment with a brief interview for mental status (BIMS) score of nine out of 15. The resident required substantial assistance from staff for most activities of daily living (ADL). The MDS assessment documented the resident did not have physical or verbal behaviors directed at others or other behavioral symptoms not directed toward others during the assessment period. B. Record review A progress note, dated 8/31/25 at 7:20 p.m., revealed a nurse was standing at her cart when she looked down the hall and observed Resident #17 attempting to kick another resident (Resident #19). Resident #19 was holding Resident #17's legs and pulling at them. The nurse ran down the hall and (continued on next page)

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