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	02/19/2026

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 - 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 observations, record review and interviews, the facility failed to ensure two (#5, and #8) of six residents reviewed out of 13 sample residents were kept free from resident-to-resident physical abuse.Specifically the facility failed to: -Protect Resident #8 from physical abuse by Resident #14; and, -Protect Resident #5 from physical abuse by Resident #9. Findings include:I. Facility policy and procedureThe Abuse, Neglect, Exploitation and Misappropriation Prevention Program Policy and Procedure, revised April 2021, was provided by the nursing home administrator (NHA) via email on 2/19/26 at 2:15 p.m. It read in pertinent part, Residents have the right to be free from abuse, neglect, misappropriation of resident property and exploitation. This includes but is 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; consultants; volunteers; staff from other agencies; family members; legal representatives; friends; visitors; and/or any other individual. Develop and implement policies and protocols to prevent and identify: abuse or mistreatment of residents. Establish and maintain a culture of compassion and caring for all residents and particularly those with behavioral, cognitive or emotional problems. Implement measures to address factors that may lead to abusive situations, for example: adequately prepare staff for caregiving responsibilities; provide staff with opportunities to express challenges related to their job and work environment without reprimand or retaliation; instruct staff regarding appropriate ways to address interpersonal conflicts; and help staff understand how cultural, religious and ethnic differences can lead to misunderstanding and conflicts.II. Incident of physical abuse by Resident #14 towards Resident #8 on 1/31/26A. Facility investigationThe facility abuse investigation report was provided by the NHA on 2/17/26 at 5:15 p.m.The investigation documented the date of the incident as 1/31/26 at 11:00 p.m.The investigation revealed that Resident #14 made contact with Resident #8 with a coke can to the side of Resident #8's face. This took place in the men's secured unit dining area. The residents were separated and placed on frequent monitoring by the facility. The police, the physician and all appropriate parties were notified.The investigation documented Resident #8 had severe cognitive impairments with a brief interview for mental status (BIMS) score of four out of 15. Resident #8 had a history of behavioral issues related to dementia . The investigation documented Resident #14 was cognitively intact with a BIMS score of 14 out of 15 and had a history of behavioral issues related to dementia. The incident was not witnessed by staff. The victim (Resident #8) was evaluated for changes in condition and assessed by a nurse on 2/1/26. Resident #8 sustained a skin tear to the left corner of the eye and was treated. The physician (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	investigation indicated that only Resident #5 was hit.C. Resident #5 (victim)1. Resident statusResident #5, age greater than 65, was admitted on [DATE]. According to the February 2026 CPO, diagnoses included fracture of left forearm, type 2 diabetes mellitus, dementia with behavioral disturbance and bipolar disorder. The 1/16/26 MDS assessment revealed the resident had moderate cognitive impairment with a BIMS score of eight out of 15. He was dependent for lower body dressing. He required substantial/maximal assistance for toilet transfers, shower transfers, shower/bathing, toileting hygiene, upper body dressing and for wheeling manual wheelchair. He required partial/moderate assistance with oral hygiene and personal hygiene. He required supervision/touching assistance for sit to stand transfers and chair to bed transfers. The assessment documented he had no behavioral symptoms, rejection of care or wandering according to the assessment.2. Record reviewResident #5's behavioral care plan, initiated 2/17/26 (during the survey), revealed the resident exhibited and was at risk for behavioral symptoms due to bipolar disorder and dementia with behavioral disturbance. Pertinent interventions included providing activities assessment for diversional activities, anticipating the resident's needs and meeting promptly, documenting and recording behavioral episodes, encouraging the resident to verbalize his feelings, obtaining psychiatric consultation as indicated, sending a referral for counseling services. The 2/10/26 at 6:44 p.m. nurse note revealed that at 3:30 p.m. the nurse was notified by the CNA-Med that this resident was hitting another resident (Resident #5) in the hallway. The nurse went to check on both residents right away and staff members had already separated them. When the resident was asked, he said the other resident cursed bad words to him and he hit him on his face. The writer assessed the resident for injuries and notified the DON for a head to toe assessment, vital signs were initiated and within normal baseline limits, a neurological assessment was done with no abnormality noted. The resident's emergency contact, physician and the NHA were notified.The 2/11/26 at 10:01 a.m. IDT behavioral note, documented as a late entry, revealed Resident #9 was wandering past Resident #5's room and they were verbally aggressive with each other, causing Resident #9 to strike out at Resident #5 and making contact with his head. The note documented the residents were separated, assessed and placed on 15-minute checks. Resident #9 was assisted to his room. D. Staff interviewsCNA #1 was interviewed on 2/19/26 at 10:17 a.m. CNA #1 said of all the residents in the men's secured unit, Resident # 9 was very mean and she was a little scared of him. CNA #1 she was told about the altercation between Resident #5 and Resident #9. CNA #1 said she did not know if both residents were hit or just Resident #5 but that Resident #9 ended up on the floor. CNA #2 was interviewed on 2/19/26 at 10:28 a.m. CNA #2 said she was told about the altercation between Resident #9 and Resident #5 and that Resident #9 had hit Resident #5 in the face. CNA #2 said she was not sure how Resident #9 ended up on the floor. CNA #2 said she was not given any techniques to prevent a further recurrence other than to watch and keep them separated. IV. Additional staff interviewsLicensed practical nurse (LPN) #1 was interviewed on 2/19/26 at 10:32 a.m. LPN #1 said she had not worked on the men's unit for a while so she had not been informed about any of the resident-to-resident altercations that had occurred recently. LPN #1 said it probably would be a good idea to know so that she could watch out and keep certain residents apart or be aware of any interventions.The NHA, the DON and the social services assistant (SSA) were interviewed together on 2/19/26 at 12:15 p.m. The NHA said a QAPI meeting was held on 2/10/26 and the next one would be held on 3/10/26. The NHA said the facility normally went through all reportable incidents and discussed them at the QAPI meetings. The NHA said they had not discussed the 2/10/26 incident in QAPI yet between Resident #5 and Resident #9 but would do so at the 3/10/26 meeting. The NHA said the process for an abuse investigation consisted of reporting to him (the abuse coordinator), he would report to the State agency, and then (continued on next page)

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