STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	075257	A. Building B. Wing	12/30/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Riverside Health Care Center, Inc.	745 Main St East Hartford, CT 06108

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. (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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(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	**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on clinical record reviews, review of facility policy, and interviews for one (1) of four (4) sampled residents (Resident #1) reviewed for an allegation of resident-to-resident abuse, Resident #1 was not provided the right to be free from physical abuse when Resident #1 was punched in the face by Resident #2 following an earlier verbal altercation between Resident #1 and Resident #2. The findings include:Resident #1's diagnoses included anxiety disorder, persistent mood disorder, and major depressive disorder. The quarterly Minimum Data Set assessment dated [DATE] identified Resident #1 had a Brief Interview for Mental Status score of fifteen (15) out of fifteen (15) indicating Resident #1 was alert and oriented, utilized a wheelchair for mobility, and was able to self-propel independently once in the wheelchair. The resident care plan identified Resident #1 had the potential to be verbally aggressive, poor impulse coping, and poor boundary setting. Resident #2's diagnoses included quadriplegia, generalized anxiety disorder, and depression. The quarterly Minimum Data Set assessment dated [DATE] identified Resident #2 had a Brief Interview for Mental Status score of fifteen (15) out of fifteen (15) indicating Resident #1 was alert and oriented, utilized a wheelchair for mobility, and was able to self-propel independently once in the wheelchair. The resident care plan identified Resident #2 had the potential to be verbally aggressive. The nurse's progress note dated 12/7/25 at 2:02 PM identified Resident #1 was witnessed having a physical altercation with another resident across from the coffee shop on the main floor. The note indicated the residents were separated, an in-house emergency call was made, nursing responded and conducted a full assessment, 911 was called, and Resident #1 was transferred to the hospital. The nurse's progress note dated 12/7/25 at 4:39 PM identified a resident reported to staff that they witnessed Resident #2 wheel up to another resident (Resident #1) who was seated in a wheelchair in the Front Lobby and started punching another resident. The note indicated the incident was witnessed by other residents who informed the receptionist and she activated the in-house emergency response. The note identified Resident #2 was noted to have a blood stain to the left side of the nose area with a small abrasion. The note indicated after several attempts to transfer Resident #2 to the hospital for a psych evaluation, at approximately 4:12 PM Resident #2 was transferred to the hospital in restraints. The Facility Reported Incident form dated 12/7/25 identified at 1:20 PM staff were notified of a physical altercation between Resident #1 and Resident #2 near the front lobby. The report indicated a resident witnessed Resident #2 wheel up to Resident #1 who was seated in a wheelchair and Resident #2 started punching Resident #1 without provocation. The report identified Resident #2 stood up from the wheelchair and continued to hit Resident #1 with a closed fist on the right side of the face. The report was indicated Resident #1 was noted with bleeding from the left eye and nostrils, with redness and bruising to the outer area of the left eye. The investigation identified Resident #1 was punched in the face with a closed fist by Resident #2 on 12/7/25 at 1:20 PM while in the front lobby area, near the recreation room. The investigation indicated there had been a verbal altercation earlier that day, 12/7/25 when Resident #1 saw Resident #2 on his/her unit speaking with a staff member. The hospital Discharge summary dated [DATE] identified Resident #1 was admitted to the hospital on [DATE] with diagnoses of open fracture of the nasal bone, hematoma of the nasal septum, periorbital hematoma, and open fracture of the ethmoid bone (a square bone at the root of the nose). Interview with Resident #1 on 12/30/25 at 10:50 AM indicated he/she saw Resident #2 on the unit talking to an aide after lunch on 12/7/25 and did not want Resident #2 on the unit. Resident #1 indicated he/she left the unit, went downstairs to the front lobby area, and when downstairs, Resident #2 appeared, came up in his/her chair and tangled it up with mine. Resident #1 indicated he/she lifted his/her arm up to protect him/herself when Resident #2 approached and then was punched by Resident #2 to the left side of the face multiple times. Interview and review of the Facility Reported Incident report with Director of Nursing (DON) on 12/30/25 at 11:02 AM identified a verbal altercation between Resident #1 and Resident #2 occurred on 12/7/25 on the fourth floor and then led to physical contact in the front lobby area, Resident #2 punched Resident #1 in the face on 12/7/25 around 1:20 PM. The DON identified following the incident, Resident #2 no longer resided at the facility. Review of facility Abuse policy dated January 2023 identified abuse as the willful infliction of injury, unreasonable confinement, intimidation, or punishment with resulting physical harm, pain, or mental anguish and directed that each resident has the right to be free from abuse and will not be subjected to abuse by anyone, including other residents. The facility identified the deficient practice and developed an immediate plan of correction for past noncompliance. DON/Designee will