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	01/22/2026

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 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. Based on observations and interviews, the facility failed to ensure all drugs and biologicals were properly stored, secured and labeled in accordance with accepted professional standards. Specifically, the facility failed to:-Ensure medication and treatment carts was kept locked when not being monitored by nursing staff;-Ensure residents' medications were stored in a locked cabinet when not being monitored by the medication administration nurse; and,-Ensure residents' medications were not prepoured into medication cups, stacked on top of one another on the medication cart and left unattended in a common area of the facility.Findings include:I. Facility policy and procedureThe facility policy for medication storage was requested on 1/22/26 at 3:48 p.m., however, the policy was not provided by the end of the survey on 1/22/26. II. ObservationsOn 1/20/26, from 1:00 p.m. to 2:00 p.m., and again on 1/21/26, from 9:48 a.m. to 11:20 a.m., the treatment cart closest to the front entrance was observed to be unlocked and unmonitored by nursing staff.On 1/22/26, from 12:15 p.m. to 12:30 p.m., the medication cart was observed to be unlocked. The assigned medication nurse, registered nurse (RN) #1, was not in sight of the medication cart. On top of the medication cart was a prefilled insulin syringe and several paper medication cups labeled with different residents' names. Each of the medication cups contained residents' medication. Each paper medication cup was stacked on top of each other so that the bottom of the cup was touching the surface of another resident's medication. In addition, there was a plastic medication cup containing an unknown medication at the top of the stack of prepoured medication cups. The director of nursing (DON) was notified of the concern when the medication administration nurse did not return to the cart for an extended period of time. The DON immediately called for RN #1 to return to the medication cart and educated RN #1 on proper medication administration and storage. The DON talked to RN #1 regarding unattended medications and RN #1 was brought to the medication cart and shown the unsecured medications. RN #1 said she had just left the cart unattended to go into the supply room. The DON informed RN #1 that leaving medications on top of a medication cart was unacceptable.On 1/22/26 at 2:55 p.m. the treatment cart closest to the front entrance was observed to be unlocked and unmonitored by RN #1.III. Staff InterviewsLicensed practical nurse (LPN) #2 was interviewed on 1/22/26 at 3:00 p.m. LPN #2 said both the treatment and the medication carts should be kept locked when not being monitored by the floor nurse. He showed the contents of the treatment cart, which included wound care supplies and prescription medications. LPN #2 said he had the keys to the cart if he needed something out of it and then locked the cart and said it was to be locked at all times. The DON was interviewed on 1/22/26 at 1:35 p.m. The DON said the expectation was for the nurses to keep the medication and treatment carts locked when not being accessed by the nurse. The DON said prepouring of medications was not allowed. The DON said all nursing staff would receive education on the expectation for proper medication storage.

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 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide and implement an infection prevention and control program. Based on observations and interviews, the facility failed to maintain an infection control program designed to provide a safe, sanitary and comfortable environment to help prevent the development and transmission of diseases and infection.Specifically, the facility failed to follow proper infection control practices during wound care for Resident #4.Findings include:I. Professional referenceAccording to the Centers for Disease Control and Prevention (CDC) Guideline For Hand Hygiene In Health Care Settings, (2/27/24) retrieved on 2/3/26 from https://www.cdc.gov/clean-hands/hcp/clinical-safety, Efficacy of Promotion and Impact of Improved Hand Hygiene: evidence supports the belief that improved hand hygiene can reduce health-care-associated infection rates. Failure to perform appropriate hand hygiene is considered the leading cause of health-care-associated infections and spread of multiresistant organisms and has been recognized as a substantial contributor to outbreaks.II. ObservationsOn 1/22/26 at 10:00 a.m. licensed practical nurse (LPN) #1 was observed performing wound care for Resident #4. The following was observed: LPN #1 gathered and brought all wound care supplies and the physician's order for wound care from the resident's chart into Resident #4's room. -LPN #1 did not perform hand hygiene before opening the facility's treatment cart, touching the treatment supplies and bringing the wound care supplies to the resident's room. LPN #1 placed the wound care supplies on top of Resident #4's bedside table. -LPN #1 did not sanitize the table's surface prior to laying out and setting up the wound care treatment supplies on top of the table. -LPN #1 placed the wound care scissors obtained from the wound care cart on Resident #4's bedside table without sanitizing the wound care scissors LPN#1 proceeded to put on gloves without performing hand hygiene and removed Resident #4's wound dressing. The wound dressing was slightly soiled with yellow discharge from the wound. After removing Resident #4's old wound dressing, LPN#1 opened a bottle of sterile saline with the same soiled gloves she removed the old dressing with and set the bottle on the unclean bedside table. -LPN #1 did not perform hand hygiene prior to opening the bottle of saline. After handling the saline bottle, LPN #1 removed her soiled gloves, but did not perform hand hygiene. LPN #1 proceeded to reach into the box of clean unused gloves (without performing hand hygiene) and pulled out a new pair of gloves. LPN #1 put on the new pair of gloves without performing hand hygiene.After putting on the new pair of gloves, LPN #1 proceeded to pour saline on a clean gauze pad to clean Resident #4's open wound. LPN #1 picked up the wound care scissors from the resident's soiled bedside table and used the scissors to cut an antimicrobial dressing material that she then placed onto Resident #4's open wound. -LPN #1 did not sanitize the wound care scissors prior to cutting the antimicrobial dressing and putting it onto the resident's wound.LPN #1 next applied an ointment to Resident #4's wound and covered the wound with a foam covered bandage, an ace wrap and a hard plastic brace. LPN#1 proceeded to wrap the brace and the resident's arm with another ace bandage and cut off the velcro with the unsanitized scissors. III. Staff interviewsThe director of nursing (DON) was interviewed on 1/22/26 at 1:35 p.m. The DON said poor wound care practices were not acceptable and she would educate the nursing staff on proper infection control practices when performing wound care.