

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 065110	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 12/30/2025
NAME OF PROVIDER OR SUPPLIER Red Cliffs Post Acute		STREET ADDRESS, CITY, STATE, ZIP CODE 2901 N 12th St Grand Junction, CO 81506	
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 0689 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure that a nursing home area is free from accident hazards and provides adequate supervision to prevent accidents. (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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<p>F 0689</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>**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 #7) of four residents reviewed for accident hazards received adequate supervision out of 11 sample residents. Specifically, the facility failed to put effective person centered interventions in place to prevent repeated falls for Residents #5 and Resident #7. Findings include: I. Professional reference The National Council of Certified Dementia Practitioners (2026). Fall Prevention for Individuals with Dementia: Tips for Caregivers, retrieved 1/5/26 from http://www.nccdp.org/fall-prevention-for-dementia-patients-tips-for-caregivers/ read in pertinent part, Falls are a serious concern for individuals living with dementia and the consequences can be devastating. As cognitive decline progresses, physical abilities often become impaired, leading to an increased risk of falls. For caregivers, managing risks can prevent injuries and preserve the dignity and independence of loved ones. Dementia and falls are closely linked due to the cognitive and physical changes that occur as the disease progresses. As dementia affects memory and judgement, it also impacts coordination, balance, and motor control. In addition, emotional factors such as anxiety can contribute to fall risks. When individuals with dementia are anxious, they may move erratically or resist help, increasing their chances of losing their balance. Medications prescribed for managing dementia or coexisting conditions such as heart disease can sometimes cause side effects like dizziness or drowsiness, which increase fall risk. Preventing falls with individuals with dementia goes beyond minimizing risks and includes improving the overall well-being and quality of life for both patients and caregivers. By understanding the causes of falls, creating a safe environment, and providing proper supervision, caregivers can significantly reduce fall risks. II. Facility policy and procedure The Activities of Daily Living (ADL) policy and procedure, revised April 2025, was received from the nursing home administrator (NHA) on 12/20/25 at 11:40 a.m. It revealed in pertinent part, Residents are provided with care, treatment, and services as appropriate to maintain or improve their ability to carry out ADLs. Residents who are unable to carry out ADLs independently receive services necessary to maintain good nutrition, grooming, and personal and oral hygiene. If residents with cognitive impairment or dementia resist care, staff will attempt to identify the underlying cause of the problem and not just assume the resident is refusing or declining care. Appropriate care and services are provided for residents who are unable to carry out ADLs independently, including appropriate support and assistance with hygiene, mobility, elimination, dining, and communication. The resident's responses to interventions are monitored, evaluated, and revised as appropriate. III. Resident #5 A. Resident status Resident #5, age greater than 65, was admitted [DATE]. According to the December 2025 computerized physician orders (CPO), diagnoses included stroke, dementia, anxiety, depression, malnutrition, unsteadiness on feet, need for assistance with personal care, bilateral hearing loss, communication deficit, hypertension and knee arthritis. The 10/2/25 minimum data sets (MDS) revealed the resident had moderate cognitive impairment with a brief interview for mental status (BIMS) score of 12 out of 15. The resident required maximum assistance from staff, where staff provided more than half of the effort, for toileting, upper and lower body dressing, putting on and removing footwear, oral hygiene, toileting hygiene, sitting and lying in bed, standing and transfers. The resident required moderate assistance, where staff provided less than half of the effort, for bed mobility. The assessment documented the resident was frequently incontinent of bladder and bowel and had no toileting programs during the look-back period. Resident #5 was prescribed anti-anxiety and anti-depressant medication and blood thinning medication. Resident #5 used a manual wheelchair independently, after staff assisted with transfers and wore a wander/elopement risk alarm. The assessment revealed Resident #5 required eyeglasses for adequate vision. B. Resident observation On 12/30/25 at 10:30 a.m. Resident #5 was sleeping on her bed. On Resident #5's bedside table there was an empty cup, a bottle of room temperature iced tea that was almost empty and her eyeglasses. The bedside table was near the head of Resident #5's bed. Resident #5 had a manual wheelchair positioned next to the foot of her bed. There was a white piece of paper on the wall across from the foot of Resident #5's bed that read call don't fall. The font lettering was light yellow and offered minimal contrast with the background. Resident #5's hearing aids sat on a charger across from the foot of Resident #5's bed, out of her reach. Resident #5's wheelchair had no visible name or room identifiers. C. Record review 1. Care plan and assessments Resident #5's fall prevention care plan, initiated 6/25/25, identified Resident #5 was at risk for falls related to altered balance while standing and/or walking, altered mental status, antipsychotic medications and antidepressant medication. Interventions</p>		