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	06/16/2026

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 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. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observations, record review and interviews, the facility failed to ensure an environment free from risk of accidents and hazards for one (#1) of three residents reviewed for accident hazards out of nine sample residents.Specifically, the facility failed to ensure neurological assessments were completed after Resident #1's unwitnessed fall, which resulted in a head injury.Findings include:I. Facility policy and procedureThe Head Injury policy, revised October 2025, was provided by the nursing home administrator (NHA) on 6/16/26 at 4:15 p.m. It read in pertinent part, It is the policy of this facility to report potential head injuries to the physician and implement interventions to prevent further injury. Assess residents following a known, suspected, or verbalized head injury. The assessment shall include, at a minimum: vital signs, general condition and appearance, neurological evaluation for changes in physical functioning, behavior, cognition, level of consciousness, dizziness, nausea, irritability, slurred speech or slow to answer questions, evaluation of the head, eyes, ears, and nose for significant changes in vision hearing, smell or bleeding, any injuries to head, neck, eyes, or face including lacerations, abrasions or bruising, pain assessment. Perform neurological checks as indicated or as specified by the physician.II. Resident #1A. Resident statusResident #1, age greater than 65, was admitted on [DATE]. According to the June 2026 computerized physician orders (CPO), diagnoses included dementia, heart disease, malnutrition and dysphagia (difficulty swallowing).The 4/1/26 minimum data set (MDS) assessment revealed the resident had moderate cognitive impairment with a brief interview for mental status (BIMS) score of 10 out of 15. The resident required supervision from staff for eating, walking at least 10 feet and transfers and moderate assistance for hygiene, showering and dressing. B. Resident interview and observationOn 6/15/26 at 1:30 p.m. Resident #1 was walking in the hallway immediately outside of her room. Resident #1's skin had large yellow areas (bruises) on both of her cheeks and forehead, each at least three centimeters (cm) to four cm wide by three cm to four cm long. In the center of both yellow areas on each cheek was a small purple one cm by one cm area. Resident #1 said she could not remember well, but she said she had fallen one night. Resident #1 said she hurt her head and had head pain after she fell. C. Record reviewA nursing progress note, dated 5/23/26 at 3:09 a.m., documented that at 2:00 a.m., staff members heard a loud noise from Resident #1's room and found the resident lying on the floor next to her bed. It documented Resident #1 said when she stood up from bed, she lost her balance and fell. It documented a four cm by four cm hematoma (a collection of blood from an injury) with a small abrasion on the right side of her forehead. A document for Resident #1 titled Neurological Record was provided by the NHA on 6/16/26 at 12:45 p.m. The document revealed the following instructions: document the date and time of each assessment, including level of consciousness, pupil response, motor functions and hand grasps, extremities, pain response and vital signs. It documented the initial assessment was to be completed in the resident's electronic medical record (EMR), and then written (hard copy/paper) documentation every 15 minutes for one hour, every 30 minutes for two hours, every hour for two hours and then every shift for 72 hours. Initial assessments were documented on the form.Review of the Neurological Record for Resident #1 revealed complete written documentation (continued on next page)

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE	TITLE	(X6) DATE

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F 0689 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	of the neurological shift assessments was missing at the following times following the resident's fall on 5/23/25:-On 5/24/26, the day shift and evening shift assessments did not include documentation for Resident #1's level of consciousness , pupil response, hand grasps, motor response and pain response and it was not signed by the nurse.-On 5/24/26, the night shift assessment documented Resident #1 refused pupil response and motor assessments, however, there was no documentation in the EMR that the physician was notified of Resident #1's refusal of these assessments.-On 5/25/26, the day shift and evening shift assessments did not include documentation for Resident #1's level of consciousness, pupil response, hand grasps, motor response and pain response.-On 5/25/26, the night shift assessment documented Resident #1 refused pupil response and motor assessments, however, there was no documentation in the EMR that the physician was notified of Resident #1's refusal of these assessments. -On 5/26/26, the day shift assessment did not include documentation for Resident #1's level of consciousness, pupil response, hand grasps, motor response and pain response.A nursing progress note, dated 5/26/26 at 2:05 p.m., documented Resident #1 had worsening confusion, inability to walk, headache and dizziness and was unable to lay flat. It documented that she was responsive to questions. Physician's orders were received and Resident #1 was transferred to the hospital.III. Staff interviewsThe director of nursing (DON) was interviewed on 6/16/26 at 2:50 p.m. The DON said the physician was notified of Resident #1's fall on 5/23/26. The DON said after Resident #1 was transferred to the hospital on 5/26/26, she (the DON) reviewed the documentation for Resident #1's neurological assessments and found there was missing documentation of the assessments. The DON said each scheduled neurological assessment should have been completed and the physician notified if Resident #1 refused assessments at any time. The DON said she had not met with licensed practical nurse (LPN) #2 to review the missed documentation of Resident #1's neurological assessment. The DON said she reviewed the missed documentation and provided education to RN #1 and certified nurse aide with medication authority (CNA-Med) #1. The DON said education was provided to all nursing staff to ensure neurological assessments were completed and documented, however, she had not reinforced education for contacting the physician if residents refused any part of the neurological assessments.Registered nurse (RN) #2 was interviewed on 6/16/26 at 6:20 p.m. RN #2 said he was Resident #1's nurse on the night she fell (on 5/23/26). RN #2 said after the fall, Resident #1 had a large hematoma on the right side of her head. RN #2 said Resident #1 told him that she stood up and her legs gave out. RN #2 said he contacted the physician and began neurological checks per the facility's protocol.