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	01/14/2025

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 - Some	Ensure that a nursing home area is free from accident hazards and provides adequate supervision to prevent accidents. 43135 Based on observations, record review and interviews, the facility failed to ensure one of three units were free from accident hazards. Specifically, the facility failed to ensure the alarm on the door to the outside secured patio was functioning properly. Findings include: I. Facility policy and procedure On 1/13/25 at 12:49 p.m. the director of nursing (DON) said the facility followed the state guidelines for the secured unit. The DON provided a copy of the state guidelines, which read read in pertinent part, Any facility that has one or more resident care units that are secured to prohibit free egress of residents shall comply with the standards in this section in addition to all other applicable requirements of this chapter. Staff in the secure environment shall be experienced and trained in the particular needs and care of its residents. The facility shall identify its method for securing the area and establish and implement procedures for monitoring the effectiveness of the security system. II. Observations (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 0689 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	On 1/13/25 at 12:15 p.m. the back door on the all-male secured unit was observed. The back door was not visible from the nurse's station. There were no cameras near the door to transmit a live visual for the staff at the nurse's station. The alarm on the door was broken and did not audibly alert staff if the door was opened. The back door provided direct access to a courtyard with uneven surfaces. When standing inside there was a keypad on the right side of the door. The keypad was used to reset the door lock and turn off the alarm. Above the door was a long thin green flashing light. When the door arm was pushed on the green light flashed from green to red several times. During this time the door could be pushed open. When the door was closed, it was locked from the outside. The courtyard had a covered smoking area. The courtyard also had a wooden gate which opened to a field. The wooden gate had an alarm system that the facility staff nor facility management knew how to operate, nor where to turn off the gate alarm and reset it (see interviews below). On 1/13/25 at 12:15 p.m. certified nurse aide (CNA) #2 pushed on the door crossbar and when the lights flashed from red to green, the door was able to be pushed open. CNA #2 stepped outside into the courtyard and no alarms sounded to notify the staff that the door had been opened. Three male residents noticed the door open and quickly attempted to walk through the opened door. On 1/13/25 at 4:10 p.m., CNA #4 was seated next to the door to the outside patio on the secured unit. CNA #4 said they were assigned to stay by the door until 10:00 p.m. and then another staff member was to take her place for the next shift. On 1/14/25 at 3:00 p.m. the corporate consultant nurse (CCN), the nursing home administrator (NHA) and the DON demonstrated that the door was fixed. The alarm sounded loudly when the door was opened. III. Staff interviews CNA #1, CNA #2 and CNA #3 were interviewed together on 1/13/25 at 12:20 p.m. CNA #1 said the alarm had not sounded when the door was opened by a resident for several months. CNA #1 said the staff rounded hourly on the 35 residents and tried to keep an eye on the three residents who often pushed on the door crossbar and attempted to get outside. CNA #1 said to keep an eye on three men meant to hope to know where they were located at all times. CNA #1 said they had never been trained on how to set or reset the egress door in the secured unit. CNA #1 said the residents in the male secured unit must be supervised when outside because the ground was uneven, which had concrete walk ways, and rock gardens that could be tripped on. CNA #2 said about 10 out of the 35 men in the secured unit went out to smoke seven times per day. CNA #2 said the men were escorted outside by two staff members, while one staff member walked up and down the hallway in front of the egress door to keep men from pushing on the door to follow the smokers outside. CNA #2 said it was difficult to keep an eye on everything on the secured unit and to make sure no one escaped. CNA #2 said they were never trained how to set or reset the door so that it locked. CNA #2 said the alarm did not work to notify the staff if a resident opened the door. CNA #3 said the alarm and door system had not worked properly for several weeks. CNA #3 said the old maintenance director was told many times but the door was never fixed. CNA #3 said a previously facility ownership company had trained staff how to use the door and its alarm, but there had been no training with the new company. (continued on next page)

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F 0689 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	CNA #5 was interviewed on 1/13/25 at 3:50 p.m. CNA #5 said in the seven months of working in the facility on the memory care unit the alarm never sounded to alert the staff if a resident went out the door from the secured unit to the outside. CNA #4 said one time a few weeks prior she found two residents sitting unattended outside in the courtyard and she brought them back inside. She said the alarm did not sound to warn staff that the door was opened. The DON was interviewed on 1/13/25 at 4:00 p.m. The DON said the courtyard to the male resident's secured unit should never have residents in it unsupervised. The DON said he was unaware the alarm was broken to the egress door on the secured unit. The NHA, the CCN and the DON were interviewed together on 1/13/25 at 4:05 p.m. The NHA, the CCN and the DON said the corporate plant operations manager (CPOM) and the facility environmental service director (ESD) had begun a plan to immediately fix whatever was broken on the door, as well as the alarm that was identified during the survey. The NHA said until the door was fixed correctly a CNA would sit next to the door to ensure the resident's safety. The NHA said the staff would be placed outside the door until the alarm was fixed and had been tested several times. The NHA was interviewed on 1/14/25 at 9:30 a.m. The NHA said the door and alarm had been fixed. He said a CNA would sit outside the door until the door had several safety inspections. The NHA said an action plan was created for the door on the memory care unit. The NHA said the action plan included how the facility staff would be trained on how the doors and alarms operated. (see action plan below). The NHA said none of the 35 men on the secured unit should be in the courtyard unsupervised. The ESD was interviewed on 1/14/25 at 2:15 p.m. The ESD said he started working at the facility seven days ago. The ESD said he was part of the team that fixed the door the previous night on 1/13/25. The ESD said the alarm had not sounded and a part was ordered. He said the part arrived today on 1/14/25and was immediately put in the alarm system. The ESD said the egress door and alarm worked correctly now. He said he would check the door daily for a week to make sure the door alarm worked correctly. The ESD said the NHA had an action plan for the door to be checked weekly. He said he used a computer system to enter maintenance orders. The ESD said today he and the NHA implemented that the NHA would receive work orders also from the maintenance system. The ESD said he had an assistant who came in today to learn about the security systems for the door in the secured unit. The NHA was interviewed on 1/14/25 at 2:20 p.m. The NHA said no one told him that the door on the secured unit had not operated correctly, nor did anyone inform him about the alarm not sounding. The NHA said he assumed the staff verbally told the prior maintenance director and that person never told anyone or fixed the situation. The NHA said he reviewed the electronic work order system and did not see any maintenance requests for the door. The NHA said the gate in the courtyard was also updated at the time the egress door alarm was fixed. D. Facility follow-up The facility action plan was provided via email on 1/14/25 at 10:27 a.m. from the NHA. It revealed in pertinent part, (continued on next page)

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F 0689 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	The identification of the problem: The exit door on the Mountain View unit (men's secured unit) to the outside courtyard no longer alarms. When the door was pushed the red/green light would blink back and forth. The door was not secured and could be opened. The alarm to the outside gate would only alarm when pressure was being applied. Once the magnet disengaged it stopped alarming. Identification of other potential problems/concerns: This could be a potential hazard due to residents attempting to exit seek going unnoticed. This could also have caused a potential concern if a resident was able to leave the facility, enter into the courtyard and then would be unable to get back into the facility. Corrective action or systemic changes: Upon knowledge of the issue with the door, a staff member was placed next to the door going to the courtyard. The staff member that monitored the exit, was responsible to to log any residents that attempted to exit seek out the door. On 1/13/25 the regional director of plant operations (RDPO) upon assessment utilized the alarm to gate (the) secure door. The courtyard door was functioning during testing. The door would continue to be monitored until the QAPI (quality assurance and performance improvement meeting) was completed. Upon resolving the door, the staff would monitor the residents who went outside for smoking and would be marked on roster upon entering the courtyard and again at completion of smoke break to verify resident count. This will remain in place until the gate is secured, and the alarm is functioning. An alarm part was ordered on 1/13/2025 to repair the alarm system. The part is scheduled to arrive at the facility on 1/14/25. On 1/14/25 the ESD will reach out to (company name) to address the gate. The goal is for it to function with an alarm until code was entered to resolve the alarm. NHA was added to (name) computer work order system, the program where maintenance requests and other facility information is stored. Education was provided to staff on door process and utilizing (maintenance requests) work order communications and informing the ESD. Responsible party and corrective action/completion: The NHA and the ESD would be responsible for ensuring completion and repair of the alarm system at the door. The completion date for repairing the door alarm is 1/15/25. -However, the action plan was not created until 1/13/25, during the survey.