

Department of Health & Human Services
Centers for Medicare & Medicaid Services

Printed: 10/09/2026
Form Approved OMB
No. 0938-0391

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 07/22/2026
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 0684 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide appropriate treatment and care according to orders, resident's preferences and goals. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on record review and interviews, the facility failed to ensure one (#1) of three residents received treatment and care in accordance with professional standards or practice out of eight sample residents. Specifically, the facility failed to complete a timely assessment after Resident #1 experienced symptoms of a urinary tract infection (UTI) and an acute kidney injury. Findings include: I. Facility policy and procedure The Change in a resident's condition or status policy, revised February 2021, was provided by the nursing home administrator (NHA) on 7/22/26 at 5:39 p.m. It revealed in pertinent part, A significant change of condition is a major decline or improvement in the resident's status that: will not normally resolve itself without intervention by staff or by implementing standard disease-related clinical interventions (is not self-limiting); impacts more than one area of the resident's health status; requires interdisciplinary review and/or revision to the care plan; and ultimately is based on the judgment of the clinical staff and the guidelines outlined in the Resident Assessment Instrument. Prior to notifying the physician or healthcare provider, the nurse will make detailed observations and gather relevant and pertinent information for the provider, including (for example) information prompted by the Interact situation, background, assessment, and recommendation (SBAR) communication form. II. Resident #1A. Resident status Resident #1, age less than 65, was admitted on [DATE] and discharged to the local area hospital on 7/10/26. According to the July 2026 computerized physician orders (CPO), diagnoses included multiple sclerosis (MS), neuromuscular dysfunction of the bladder, chronic obstructive pulmonary disease (COPD), congestive heart failure, peripheral vascular disease, hypertension, enterocolitis due to clostridium difficile, calculus of the kidney (kidney stones) and muscle weakness. The 6/29/26 minimum data set (MDS) assessment revealed Resident #1 had moderate cognitive impairment with a brief interview for mental status (BIMS) score of nine out of 15. Resident #1 was dependent on staff for bathing, toileting, lower body dressing, footwear and personal hygiene. Resident #1 required substantial assistance with upper body dressing and set up assistance to eat. The assessment documented Resident #1 had an indwelling catheter. B. Resident representative interview Resident #1's representative was interviewed on 7/22/26 at 2:11 p.m. She said came to the facility to visit Resident #1 on 7/9/26. She said he did not look like or act like his usual self. She said he was usually very talkative and liked to joke around. She said on 7/9/26 he was quieter and was more in a somber mood. The representative said his face and skin looked very dry and almost scaly. She said she returned to the facility on 7/10/26 at approximately 6:30 p.m. She said he was very sleepy and lethargic. She said he would briefly open his eyes but then would fall back asleep. She said she felt that something was wrong. She said she noticed he had partially empty cups on his bed side table but there was very little urine in his catheter bag. She said she expressed her concerns with licensed practical nurse (LPN) #1. The resident's representative said LPN #1 told her that he had taken a pain pill, which may have been causing his (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
--	-------	-----------

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 07/22/2026
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 0684 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	sleepiness and he had a rough night the night before (7/9/26). The representative said LPN #1 told her Resident #1 had some back pain, nausea and vomiting. The representative said she told LPN #1 that Resident #1 had a history of UTIs, fluid retention and sepsis with similar symptoms. She said she was very worried that he had urinary retention and felt he should go to the hospital. The representative said LPN #1 looked at the resident's catheter bag and said he had not had input of fluids today so he would not have an output of fluids. The representative said LPN #1 pushed on his stomach/bladder and said the resident was not retaining fluid. The representative said LPN #1 told her it was after business hours but tomorrow (7/11/26) she could order a urine analysis. The representative said LPN #1 told her there was nothing she could do now. The representative said LPN #1 took his blood pressure and said he was fine. She said LPN #1 said Resident #1 could be treated at the facility, he did not need to go to the hospital and she would contact his physician. The resident's representative said she was still very worried that Resident #1 was very sick and needed to go to hospital. She said she contacted the Resident #1's power of attorney (POA) who called for the paramedics to come to take him to the hospital for an evaluation. She said the paramedics arrived at the facility and said Resident #1 had little response to them and took him to the hospital. The representative said she was later told by the hospital that Resident #1 had a significant amount of fluid in his bladder and he was septic. C. Record reviewReview of the certified nurse aide (CNA) indwelling catheter device task from 6/24/26 through 7/10/26 revealed the following. On 7/7/26 at 5:54p.m., Resident #1's urine output changed from clear to cloudy. Resident #1's urine color was documented as cloudy again on 7/8/26 at 1:11 a.m. and 7/8/26 at 5:19 p.m. On 7/9/26 at 3:10 p.m., 7/10/26 at 4:36 a.m. and 7/10/26 at 5:26 p.m. Resident #1's urine output was documented as amber on 7/9/26 at 5:24 a.m. On 7/9/26, the task documented Resident #1 had decreased urine output, with 450 milliliters (ml) urine output at 5:24 a.m. and 250 ml urine output at 3:10 p.m. On 7/10/26, the task documented Resident #1 continued to have decreased urine output, with 100 ml urine output at 4:36 a.m. and 50 ml urine output at 5:26 p.m. Review of the Resident #1 intake documentation revealed on 7/9/26, Resident #1 ate 0 to 25 % of breakfast at 9:23 a.m., ate 25 to 50% of his lunch at 1:51 p.m. and 50 to 75% of his dinner at 8:13 p.m. Prior to 7/9/26. On 7/10/26, Resident #1 ate 0 to 25% of his breakfast at 9:56 a.m. and refused his lunch and dinner. Review of Resident Resident #1's intake documentation prior to 7/9/26 revealed Resident #1 typically ate 75 to 100% of each meal. -However, the facility did not complete an assessment despite documenting changes in urine and oral intake. Review of Resident #1 CPO revealed the following order: Ondansetron 8 milligram (mg) oral tablet, give one tablet by mouth every eight hours as needed for nausea or vomiting, ordered 6/23/26. Review of Resident #1's medication administration record (MAR) revealed Resident #1 received Ondansetron 8 mg tablet for nausea on 7/10/26 at 3:16 a.m. This was the first administration of this medication. The progress note, dated 7/10/26 at 8:44 p.m. documented at approximately 6:15 p.m. LPN #1 was notified Resident #1 had a change in condition. The progress note documented LPN #1 was notified Resident #1 had not eaten or drank as usual during the day, was observed sleeping frequently and had reduced urine output. The progress note documented Resident #1 was sleeping when LPN #1 entered the room. The progress note documented responded to LPN #1's voice and was oriented times two and told LPN #1 he felt fine. The progress note documented LPN #1 obtained Resident #1's vital signs and at the time, Resident #1's hands were cool and clammy. The progress note documented Resident #1's blood pressure was 103/60 millimeters of mercury (mmHg), pulse was 94 beats per minute (BPM), temperature was 98.1 degrees Fahrenheit and oxygen saturation was 90% on room air. The progress note documented Resident #1 was clinically stable and did not meet the criteria for emergent transport. The progress note documented the nurse explained to Resident #1's (continued on next page)		

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 07/22/2026
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 0684 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	friend and representative that the resident's symptoms could be safely treated at the facility because the facility could order labs, urinalysis, intravenous (IV) fluid and antibiotics with increased monitoring at the facility. The progress note documented LPN #1 also offered to contact Resident #1's provider. The progress note documented when LPN #1 attempted to ask Resident #1 if they wanted to go to the hospital or remain in the facility, the friend and Resident #1's representative would not allow Resident #1 to answer. The progress note documented Resident #1's representative refused to listen to LPN #1's attempts to explain treatment options at the facility and did not allow sufficient time for LPN #1 to complete a comprehensive assessment before calling 911. The progress note documented emergency medical services (EMS) arrived to the facility and transported Resident #1 to the local area hospital. The progress note documented Resident #1 did not appear with acute distress during the brief assessment prior to transport by EMS. The hospital note, dated 7/11/26 at 2:59 a.m., revealed Resident #1 had an altered level of consciousness. The hospital note documented Resident #1 appeared to wake up to stimuli but did not stay awake. The hospital note documented Resident #1 experienced low blood pressure while in the emergency room, with documented blood pressures of 82/55 on 7/11/26 at 2:50 a.m., 76/48 at 2:53 a.m. and 83/56 at 2:55 a.m. The hospital note documented Resident #1 had white blood cell count and lactic acid values that were elevated but not critical. The hospital note documented Resident #1's urinalysis was positive for a UTI. The hospital note documented the initial suspected origin for Resident #1's altered mental status was suspected sepsis w/ possible component of medication accumulation in the setting of an acute kidney injury. The hospital note documented Resident #1 was admitted to the intensive care unit (ICU) for monitoring because Resident #1 was at risk for sudden deterioration requiring urgent physician intervention. Review of Resident #1's records revealed no documentation of nursing assessments for a change of condition on 7/9/26 (the onset of nausea and change in urine output or color) or 7/10/26 (continued reduced intake and low urine output with cloudy urine) prior to the progress note documenting the attempted assessment by LPN #1 at 6:15 p.m. III. Staff interviews CNA #1 was interviewed on 7/22/26 at 1:17 p.m. CNA #1 said she completed education at the facility regarding cleaning and emptying indwelling catheters at least once a year if not more often. CNA #1 said she knew to tell the nurse about any abnormal urine output when emptying a catheter including changes in color, odor and amount. CNA #1 said she typically did not report urine output to the floor nurse unless the output was abnormally low, but she was not sure what amount of urine was considered abnormally low. CNA #2 was interviewed on 7/22/26 at 1:27 p.m. CNA #2 said it was usually the CNA's responsibility to empty indwelling catheters each shift, but sometimes the floor nurse would empty the catheter bag if the CNA was busy. CNA #2 said she usually emptied the urine collection bag multiple times a shift, approximately every six hours. CNA #2 said she did not report all urine outputs to the floor nurse, but she would report any time the urine collection bag appeared empty or with abnormally low urine output; as well as any time the urine appeared cloudy, pink, red or had a foul odor. CNA #2 said she reported low urine output to the floor nurse when the collection bag had less than 100ml when she emptied it but usually did not consider what the total output was for the shift if she emptied the urine collection bag multiple times in a shift. The assistant director of nursing (ADON) and the director of nursing (DON) were interviewed together on 7/22/26 at 3:17 p.m. The DON said she remembered receiving a call from LPN #1 on 7/10/26 in the evening. The DON said LPN #1 told her Resident #1's representative wanted to transfer Resident #1 to the hospital emergently. The DON said LPN #1 told her the vital signs she obtained, and since the Resident #1's pulse was below 100 beats per minute and blood pressure was within normal limits, they did not indicate emergent transport to the hospital. The DON said she provided education to staff to attempt to handle things in (continued on next page)		

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 07/22/2026
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 0684 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	house, but they also have to honor any resident's decision if they request to go to the hospital. The ADON said the facility had the ability to send labs, urinalysis, start IV therapies and obtain antibiotics 24 hours a day and the facility was equipped to manage a UTI. The ADON said Resident #1 had a history of chronic back pain and was also on precautions for C. diff, which could cause nausea for up to one month after the acute illness, so reporting back pain nausea alone would not be enough of an indication to complete a change in condition assessment. The DON said based on the documentation of low urine output below 30 ml/hour and cloudy urine, she would want the nurse to complete a head to toe assessment in order to determine if Resident #1 had a true change in condition, and she could not determine why an assessment was not completed without speaking to the staff directly. The DON said CNAs should report changes in color, odor, or urine output to the nurse because there are many reasons that could cause low output and would require a nurse to assess what problem was occurring. The DON said she could not find an assessment for a change in condition prior to the progress note describing the events on 7/10/26. LPN #1 was interviewed on 7/22/26 at 4:47 p.m. LPN #1 said she remembered caring for Resident #1 on 7/9/26 and 7/10/26. LPN #1 said she remembered Resident #1 reported nausea during the middle of the night, but she thought since the resident recently had C. diff in June 2026 and already had an order for nausea medication, it was not a new symptom for Resident #1. LPN #1 said she remembered a young woman, who she was not sure of her relationship to Resident #1, but thought she might be the resident's niece, visited on 7/9/26. LPN #1 said at the time the visitor told LPN #1 Resident #1 wanted to leave, but LPN #1 said she did not remember the visitor reporting Resident #1 having any symptoms that night. LPN #1 said during change of shift report on 7/10/26, LPN #2 reported Resident #1 had vague symptoms of not feeling well during the day, that Resident #1 was tired and did not eat much. LPN #1 said based on the report, she planned to complete a head to toe assessment on Resident #1 as soon as she was finished getting the medication cart from LPN #2. LPN #1 said she did remember whether or not she asked LPN #2 if she completed an assessment to determine if Resident #1 had a change. LPN #1 said before she could complete an assessment, the same visitor from 7/9/26 came to the nurses station. LPN #1 said the visitor was raising her voice, stating Resident #1 appeared ill and demanded Resident #1 go to the hospital. LPN #1 said Resident #1's representative entered the room when LPN #1 was taking Resident #1's vital signs. LPN #1 said she was able to obtain vital signs but when she tried to ask additional assessment questions, the visitor and Resident #1's representative were talking over Resident #1. LPN #1 said based on Resident #1's vital signs, she tried to explain the resident's symptoms could be treated at the facility and did not require emergent transport to the local area hospital, but Resident #1's representative would not listen to her. LPN #1 said she attempted to call Resident #1's physician, but the visitor and Resident #1's representative followed her to the nurses station, continuing to raise their voice and demand Resident #1 be transferred to the hospital, so she could not reach the provider. She said when she tried to complete her assessment again and ask Resident #1 if he wanted to go the hospital, she felt Resident #1 was frustrated and stopped answering questions. LPN #1 said at this time Resident #1's representative called 911. LPN #1 said Resident #1 would not answer questions for EMS, so they honored Resident #1's representative's request to transport to the hospital. LPN #1 said CNAs would typically report changes in urine color or output to her, but she did not remember any CNA telling her about changes to Resident #1's urine output or color on 7/9/26 or 7/10/26. The ADON, the DON, and the NHA were interviewed together on 7/22/26 at 6:07 p.m. The DON said there was not documentation to show what time LPN #2 noticed changes in Resident #1's intake and urine output, and could not determine what time the changes occurred without speaking to LPN #2 directly, but the DON said it was possible LPN #2 was only (continued on next page)		

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 07/22/2026
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 0684 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	made aware of the changes occurring in Resident #2 on 7/10/26 toward the end of her shift and communicated to LPN #1 to complete an assessment. The ADON said she was able to review Resident #1's hospital notes after the interview earlier in the day, and read that Resident #1 met criteria for systemic inflammatory response syndrome (SIRS) while at the hospital, but the ADON said the resident responded well to fluids in the hospital and recovered quickly. The ADON and the DON said they believed if Resident #1's representative and visitor allowed LPN #1 to finish her assessment and contact the provider per the facility policy and procedure, they could have managed Resident #1's UTI without transferring him to the hospital. The NHA said they provided education to staff working today and planned to provide additional education to staff regarding reporting changes in urine output and color as well as completion of change in condition assessment. The NHA said they already provided this education to staff earlier in the year as well as remote video education, but they planned to complete a case study to review the events leading to Resident #1's transfer to the hospital.		