| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: | (X2) MULTIPLE CONSTRUCTION | (X3) DATE SURVEY COMPLETED |
|---|---|---|---|
| | 065286 | A. Building<br>B. Wing | 06/12/2024 |

| NAME OF PROVIDER OR SUPPLIER | STREET ADDRESS, CITY, STATE, ZIP CODE |
|---|---|
| Eagle Ridge Post Acute | 2425 Teller Ave<br>Grand Junction, CO 81501 |

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 0580<br><br>Level of Harm - Minimal harm or potential for actual harm<br><br>Residents Affected - Few | Immediately tell the resident, the resident's doctor, and a family member of situations (injury/decline/room, etc.) that affect the resident.<br><br>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 40467<br><br>Based on record review and interviews, the facility failed to inform the resident's representative of a change of condition for one (#173) of four residents reviewed for notification of change out of 45 sample residents.<br><br>Specifically, the facility failed to ensure Resident #173' s responsible party was notified after an unwitnessed fall.<br><br>Findings include:<br><br>I. Facility policy<br><br>The Fall and Fall Risk, Managing policy, revised March 2018, was provided by the facility on 6/12/24. According to the policy, a fall was: Unintentionally coming to rest on the ground, floor or lower level, but not as a result of an overwhelming external force. An episode where a resident lost his or her balance and would have fallen, if not for another person or if he or she had not caught himself, is considered a fall. A fall without injury is still a fall. Unless there is evidence suggesting otherwise, when a resident is found on the floor, a fall is considered to have occurred.<br><br>II. Resident #173<br><br>A. Resident status<br><br>Resident #173, age 68, admitted on [DATE] and discharged on [DATE]. According to the February 2024 computerized physician's orders (CPO), diagnoses included fusion of the spine, cervical region, encounter for surgical aftercare following surgery of the nervous system, acquired absence of left leg below knee, difficulty in walking, lack of coordination, dependence on a wheelchair, muscle weakness and adjustment disorder with mixed anxiety and depressed mood.<br><br>The 2/14/24 minimum data set (MDS) assessment identified the resident was cognitively intact with a brief interview for mental status with a score of 15 out 15. She required set-up assistance and supervision or touch assistance for transferring.<br><br>B. Record review<br><br>(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: 065286 | (X2) MULTIPLE CONSTRUCTION A. Building B. Wing | (X3) DATE SURVEY COMPLETED 06/12/2024 |
|---|---|---|---|
| NAME OF PROVIDER OR SUPPLIER: Eagle Ridge Post Acute | | STREET ADDRESS, CITY, STATE, ZIP CODE: 2425 Teller Ave Grand Junction, CO 81501 | |

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 0580<br><br>Level of Harm - Minimal harm or potential for actual harm<br><br>Residents Affected - Few | The contact information for Resident #173 documented two resident representatives were listed as emergency contacts #1 and #2.<br><br>III. Failure to notify the designated resident representative after a fall<br><br>A. Resident representative interview<br><br>Resident representative #1 was interviewed on 6/11/24 at 5:19 p.m. Resident representative #1 said she was not notified when Resident #173 fell while a resident at the facility, which was concerning her because the resident was there for post surgery care after she broke her neck. She said she received a photograph on 2/14/24 from the resident's care giver after the resident was discharged from the facility. The representative said Resident #173 had a bruise and swelling under her eye and cheekbone. She said Resident #173 told her she had fallen at the facility (cross-reference F689 accident hazards). The resident representative said she was the resident's power of attorney (POA) and emergency contact and should have been made aware of and notified when the resident fell .<br><br>B. Unwitnessed fall documentation<br><br>The 2/10/24 nurses note read Resident #173 had an unwitnessed fall on 2/10/24. The resident fell when she was transferring herself from her bed to her scooter and lost her balance then lowered herself to the floor. The resident was found sitting on the floor between the bed and her scooter. According to the note, there were no injuries and the resident did not hit her head.<br><br>The 2/10/24 change of condition evaluation documented in part that a change of condition had been noted. The symptoms included a fall on 2/10/24. Under the resident representative notification section, the evaluation listed Resident #173 as the family/resident representative notified on 2/10/24 at 6:10 a.m.<br><br>-The evaluation did not identify the resident's family/representative was notified after the fall.<br><br>The 2/10/24 unwitnessed incident report identified Resident #173 was notified of her fall on 2/10/24 at 6:47 a.m.<br><br>-The incident report did not identify the resident's representative was notified after the fall.<br><br>IV. Staff interviews<br><br>The director of nursing (DON) was interviewed on 6/12/24 at 11:58 a.m. The DON said staff needed to notify the physician, the DON and the power of attorney (POA) after a resident fell . The DON said the family of the resident should always be contacted when listed as the emergency contact.<br><br>The DON was interviewed again on 6/12/24 at 4:11 p.m. The DON reviewed the documented notifications after Resident #173's fall on 2/10/24. The DON said the notification of the fall should not have been the resident but the resident's family. She said the resident's emergency contact should have been notified after the fall. |

| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 065286 | (X2) MULTIPLE CONSTRUCTION A. Building B. Wing | (X3) DATE SURVEY COMPLETED 06/12/2024 |
|---|---|---|---|

| NAME OF PROVIDER OR SUPPLIER | STREET ADDRESS, CITY, STATE, ZIP CODE |
|---|---|
| Eagle Ridge Post Acute | 2425 Teller Ave<br>Grand Junction, CO 81501 |

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 0688<br><br>Level of Harm - Minimal harm or potential for actual harm<br><br>Residents Affected - Few | Provide appropriate care for a resident to maintain and/or improve range of motion (ROM), limited ROM and/or mobility, unless a decline is for a medical reason.<br><br>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 50314<br><br>Based on record review and interviews, the facility failed to ensure one (#54) of three residents with limited range of motion received appropriate treatment and services out of 45 sample residents.<br><br>Specifically, the facility failed to provide restorative therapy services to Resident #54.<br><br>Findings include:<br><br>I. Professional Reference<br><br>According to the American Association of Post-Acute Nursing (AAPACN) Guidelines for Restorative Nursing Programs, retrieved on 6/17/24 from aapacn.org/restorative-programs-guide/, The risk for functional decline in long term care residents is a serious issue that often leads to falls, pressure ulcers/injuries, weight loss, depression, and other negative outcomes. To ensure quality outcomes and to comply with federal regulation, nursing facilities must have a comprehensive and effective restorative therapy program that encourages each resident's highest level of function.<br><br>II. Resident #54<br><br>A. Resident status<br><br>Resident #54, age greater than 65, was admitted to the facility on [DATE] and readmitted on [DATE]. According to the June 2024 computerized physician orders (CPO), diagnoses included chronic obstructive pulmonary disease (COPD), diabetes and generalized muscle weakness.<br><br>The 4/9/24 minimum data set (MDS) assessment revealed the resident had moderate cognitive impairments with a brief interview for mental status (BIMS) score of 11 out of 15. The resident required set-up or clean-up assistance with eating. The resident required substantial or maximum assistance with transfers, showers, toileting and personal hygiene.<br><br>B. Resident interview<br><br>Resident #54 was interviewed on 6/5/24 at 10:14 a.m. Resident #54 said she was not receiving restorative therapy services to prevent physical decline. Resident #54 said she felt like she had become weaker since her readmission to the facility on [DATE]. Resident #54 said she wanted to work towards walking more so she could be more independent in her room.<br><br>Resident #54 said she felt both worried and sad that she was becoming more dependent on staff for assistance when she would rather work with the therapy department to keep as much of her independence as possible.<br><br>C. Record review<br><br>(continued on next page) |

| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 065286 | (X2) MULTIPLE CONSTRUCTION A. Building B. Wing | (X3) DATE SURVEY COMPLETED 06/12/2024 |
|---|---|---|---|
| NAME OF PROVIDER OR SUPPLIER Eagle Ridge Post Acute | | STREET ADDRESS, CITY, STATE, ZIP CODE 2425 Teller Ave Grand Junction, CO 81501 | |

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 0688<br><br>Level of Harm - Minimal harm or potential for actual harm<br><br>Residents Affected - Few | An interdisciplinary team (IDT) conference review summary was documented on 1/19/24 at 1:24 p.m by the social services director (SSD). The assessment documented the resident was not receiving restorative therapy services.<br><br>A physical therapy discharge summary dated, 1/26/24, documented that physical therapy services ended because of a lack of payment source for the resident's physical rehabilitation services. The discharge summary recommended a home exercise program and a restorative therapy program for the resident.<br><br>The discharge summary documented Resident #54 and facility staff were educated on positioning maneuvers, pressure relieving techniques, safe transfer techniques, assistive device use and compensatory strategies in order to facilitate functional independence for Resident #54.<br><br>-A review of the June 2024 CPO revealed the resident did not have an order for restorative nursing services.<br><br>III. Staff interviews<br><br>Certified nurse aide (CNA) #2 was interviewed on 6/10/24 at 10:38 a.m. CNA #2 said she did not know what restorative therapy services were. CNA #2 said she knew physical therapy was provided in the building, but was unsure who provided restorative therapy services to residents.<br><br>Licensed practical nurse (LPN) #6 was interviewed on 6/12/24 at 10:29 a.m. LPN #6 said she knew what restorative therapy services were, but she was not aware of any restorative therapy services being provided in the building. LPN #6 said Resident #54 was not receiving restorative therapy services. LPN #6 said Resident #54 did not have a physician's order for restorative therapy services.<br><br>The physical therapist (PT) was interviewed on 6/11/24 at 1:19 p.m. The PT said restorative therapy services were recommended for residents whenever physical therapy ended for a resident without any expectation of improvement. The PT said she had started working at the facility in March 2024 and did not know anything about residents in the facility before that time. The PT said no one in the physical therapy department had worked with Resident #54 in the last several months. The PT said she did not know the resident wished to continue working with restorative therapy services to maintain her current level of function.<br><br>The director of rehabilitation (DOR) was interviewed on 6/12/24 at 12:24 p.m. The DOR said restorative therapy services were an important maintenance program to maintain a resident's current level of function and to prevent further physical decline. The DOR said the therapy department at the facility did not complete restorative therapy services, but the therapy department would provide recommendations to the nursing staff for residents to receive restorative therapy services, which was documented in the residents' medical record. The DOR said restorative therapy services would have helped prevent physical decline for Resident #54.<br><br>(continued on next page) |

| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 065286 | (X2) MULTIPLE CONSTRUCTION A. Building B. Wing | (X3) DATE SURVEY COMPLETED 06/12/2024 |
|---|---|---|---|
| NAME OF PROVIDER OR SUPPLIER Eagle Ridge Post Acute | | STREET ADDRESS, CITY, STATE, ZIP CODE 2425 Teller Ave Grand Junction, CO 81501 | |

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 0688<br><br>Level of Harm - Minimal harm or potential for actual harm<br><br>Residents Affected - Few | The director of nursing (DON) was interviewed on 6/12/24 at 1:05 p.m. The DON said restorative therapy services were important to maintain a resident's baseline physical function. The DON said Resident #54 did not receive restorative therapy services. The DON said there was no documentation in Resident #54's medical record to indicate she received restorative therapy services. The DON said the facility had experienced significant turnover in the physical therapy department and recommendations for restorative therapy services were not communicated effectively due to the turnover.<br><br>-However, PT discharge summary documentation revealed the PT department had communicated and educated nursing staff on the restorative therapy services Resident #54 required on 1/26/24.<br><br>The nursing home administrator (NHA), the regional operations manager (ROM), and the DON were interviewed together on 06/12/24 at 4:32 p.m. The NHA said the facility had identified restorative therapy services as an area of needed improvement within the facility quality assurance and performance improvement (QAPI) committee.<br><br>The DON said the facility had been talking about the need to properly offer and complete restorative therapy services for residents in the facility. The DON said she had been working to provide restorative therapy services education to nursing staff.<br><br>The ROM said the DOR identified a need to hire a restorative therapy services aide to ensure restorative therapy services were appropriately completed.<br><br>The DON said a restorative therapy services aide would be starting in the facility in July 2024 to provide restorative services to residents. |

| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 065286 | (X2) MULTIPLE CONSTRUCTION A. Building B. Wing | (X3) DATE SURVEY COMPLETED 06/12/2024 |
|---|---|---|---|
| NAME OF PROVIDER OR SUPPLIER Eagle Ridge Post Acute | | STREET ADDRESS, CITY, STATE, ZIP CODE 2425 Teller Ave Grand Junction, CO 81501 | |

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<br><br>Level of Harm - Minimal harm or potential for actual harm<br><br>Residents Affected - Few | Ensure that a nursing home area is free from accident hazards and provides adequate supervision to prevent accidents.<br><br>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 40467<br><br>Based on record review and interviews, the facility failed to provide adequate supervision and assistance to prevent falls, and failed to assess, implement and monitor interventions consistent with resident needs for one (#173) of four residents reviewed for falls out of 45 sample residents.<br><br>Specifically, the facility failed to:<br><br>-Assess Resident #173 after a potential fall and after injuries were identified and report the potential fall;<br><br>-Monitor Resident #173 after facial injuries were identified;<br><br>-Ensure safe smoking practices were conducted for Resident #173 and care planned; and,<br><br>-Ensure interventions were care planned for Resident #173 who was identified at moderate risk for falls.<br><br>Findings include:<br><br>I. Facility policy<br><br>The Fall and Fall Risk Managing policy, revised March 2018, was provided by the facility on 6/12/24. The policy documented in pertinent part, Based on previous evaluations and current data, the staff will identify interventions related to the resident specific risk and cost to prevent the resident from falling and try to minimize complications from falling.<br><br>The staff, with input from the attending physician, will implement a resident centered fall prevention plan to reduce the specific risk factors of falls for each resident at risk or with a history of falls. If a systematic evaluation of a resident's fall risk identifies several possible interventions, the staff may choose to prioritize interventions.<br><br>If underlying causes cannot be readily identified or corrected, staff will try various interventions, based on assessment of the nature of the category of falling, until falling is reduced or stopped, or until the reason for the continuation of the falling is identified as unavoidable. In conjunction with the attending physician, staff will identify and Implement relevant interventions to try to minimize serious consequences of falling.<br><br>The Smoking Residents policy, revised October 2023, was provided by the nursing home administrator (NHA) on 6/12/24 at 4:26 p.m. According to the policy, the facility established and maintained safe resident smoking practices. The policy read in pertinent part, Any resident with smoking privileges requiring monitoring shall have direct supervision of a staff member, family member, visitor or volunteer at all times while smoking.<br><br>II. Resident #173<br><br>(continued on next page) |

| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 065286 | (X2) MULTIPLE CONSTRUCTION A. Building B. Wing | (X3) DATE SURVEY COMPLETED 06/12/2024 |
|---|---|---|---|
| NAME OF PROVIDER OR SUPPLIER Eagle Ridge Post Acute | | STREET ADDRESS, CITY, STATE, ZIP CODE 2425 Teller Ave Grand Junction, CO 81501 | |

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<br><br>Level of Harm - Minimal harm or potential for actual harm<br><br>Residents Affected - Few | A. Resident status<br><br>Resident #173, age 68, was admitted on [DATE] and discharged on [DATE]. According to the February 2024 computerized physicians orders (CPO), diagnoses included fusion of the spine in the cervical region, encounter for surgical aftercare following surgery of the nervous system, acquired absence of left leg below knee, difficulty walking, lack of coordination, dependence on a wheelchair, muscle weakness and adjustment disorder with mixed anxiety and depressed mood.<br><br>The 2/14/24 minimum data set (MDS) assessment identified the resident was cognitively intact with a brief interview for mental status (BIMS) score of 15 out 15. She required set-up and supervision or touch assistance for transferring.<br><br>The MDS assessment documented the resident did not have any falls or injuries since her admission to the facility.<br><br>III. Resident representative interview<br><br>Resident #173's representative #1 was interviewed on 6/11/24 at 5:19 p.m. The representative said Resident #173 had a fall at the facility which resulted in a bruise and swelling under her eye and cheekbone. The resident'srepresentative said she was not notified of the fall but believed the fall occurred on 2/12/24 (cross-reference F580 notification of a change in condition). She said Resident #173 told her she fell when she was outside at night smoking. She said the resident told her she slipped off her scooter and hit her face on the concrete.<br><br>IV. Resident interview<br><br>Resident #173 was interviewed on 6/11/24 at 6:51 p.m. Resident #173 said she had two falls during her stay at the facility. She said the first fall happened in the morning when she slid off her bed trying to reach for her scooter. Resident #173 said she fell a second time when she went outside alone at night to smoke. She said a cigarette fell on the ground. She said she went to reach for it and her scooter cushion slipped off and she hit the ground hard. She said a CNA came outside to smoke and found her on the ground after 10 to 15 minutes. She said the CNA notified the nurse. The resident said she asked the nurse not to make a report because she was going to be able to be discharged home soon and did not want any setbacks or concerns of her returning home. She said the nurse agreed not to report the incident and told her she hated doing accident reports. Resident #173 said she had a bruise under her eye and her face was swollen the next day. She said another CNA asked her what happened after seeing the facial injuries. The resident said she told the CNA she hit her face on her scooter's handlebars when her cushion slid from her. She said she lied because she wanted to go home and did not want to get anyone in trouble.<br><br>V. Record review<br><br>Resident #173'ssmoking care plan, initiated on 2/5/24, read Resident #173 had potential for<br><br>injury related to smoking. The resident'ssafety and hygiene was to be maintained every shift. The care plan did not identify interventions to direct staff of the safe smoking safety needs of Resident #173.<br><br>(continued on next page) |

| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 065286 | (X2) MULTIPLE CONSTRUCTION A. Building B. Wing | (X3) DATE SURVEY COMPLETED 06/12/2024 |
|---|---|---|---|
| NAME OF PROVIDER OR SUPPLIER Eagle Ridge Post Acute | | STREET ADDRESS, CITY, STATE, ZIP CODE 2425 Teller Ave Grand Junction, CO 81501 | |

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<br><br>Level of Harm - Minimal harm or potential for actual harm<br><br>Residents Affected - Few | -The review of Resident #173'scomprehensive care plan, initiated on 2/5/24, 2/6/24 and 2/9/24 and revised on 2/26/24, did not identify the resident was at risk for falls or fell at the facility.<br><br>-The care plan did not identify interventions to decrease the risk of her falls.<br><br>The 2/10/24 fall risk observation/assessment read the resident was at a moderate risk for falls and ambulated with problems and devices.<br><br>The 2/10/24 nurses note read Resident #173 had an unwitnessed fall on 2/10/24. The resident fell when she was transferring herself from her bed to her scooter and lost her balance then lowered herself to the floor. The resident was found sitting on the floor between the bed and her scooter. According to the note, there were no injuries or bruising and the resident did not hit her head.<br><br>-The review of the progress notes did not identify there was a second fall between 2/10/24 and the resident's discharge on 2/14/24.<br><br>-The review of the progress notes did not identify the resident had bruising and swelling to her face or other related injuries.<br><br>The 2/10/24 change of condition evaluation documented in part, that a change of condition had been noted. The symptoms included a fall on 2/10/24.<br><br>-The resident was not identified to have injuries to her face.<br><br>-The review of the resident'sassessments did not identify the resident had a second fall or injuries to her face from a fall or hitting her scooter.<br><br>The 2/10/24 post fall review documented the resident had not had any falls at the facility prior to the 2/10/24 fall.<br><br>The 2/10/24 fall risk observation/assessment read the resident was at a moderate risk for falls and ambulated with problems and devices.<br><br>The 2/10/24 unwitnessed incident report read Resident #173 was transfering from her bed to the scooter, lost her balance and lowered herself to the floor so she would not fall. According to the incident report, the resident was assessed after the fall and there were no injuries observed at the time of the fall.<br><br>The interdisciplinary team (IDT) fall note read Resident #173 had an unwitnessed fall on 2/10/24 at 6:32 a.m. The note did not identify the details of the fall or if the resident had injuries. According to the note, the intervention after the 2/10/24 fall was to ensure non-slip footwear or non-skid socks were on during resident transfers.<br><br>The 2/12/24 daily skilled charting form for the night shift, completed on 2/13/24 at 5:15 a.m. read the resident needed extensive assistance with transfers with two staff but was able to reposition herself in bed. According to the skilled charting, the resident had bilateral leg edema and a healing post surgical incision. No other concerns were identified for the resident's skin.<br><br>(continued on next page) |

| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 065286 | (X2) MULTIPLE CONSTRUCTION A. Building B. Wing | (X3) DATE SURVEY COMPLETED 06/12/2024 |
|---|---|---|---|
| NAME OF PROVIDER OR SUPPLIER Eagle Ridge Post Acute | | STREET ADDRESS, CITY, STATE, ZIP CODE 2425 Teller Ave Grand Junction, CO 81501 | |

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<br><br>Level of Harm - Minimal harm or potential for actual harm<br><br>Residents Affected - Few | -The skilled charting did not identify the resident had a fall or injuries that were being monitored.<br><br>The 2/13/24 daily skilled charting form for the day shift, completed on 2/13/24 at 2:22 p.m. read the resident was a current smoker and there were no signs or symptoms of distress observed and she used a motorized wheelchair. The form did not identify concerns with the resident'sskin.<br><br>-The skilled charting form did not identify the resident had a fall or injuries that were being monitored<br><br>The 2/13/24 daily skilled charting form for the night shift, completed on 2/13/24 at 5:46 a.m. did not identify the resident had a fall or injuries that were being monitored. According to the skilled charting, the resident had a healing post surgical incision. No other concerns were identified for the resident'sskin.<br><br>The 2/13/24 nurse'snote at 9:56 a.m. read day three of three post fall neurological checks. According to the note, there were no delayed injuries voiced or observed.<br><br>The review of Resident #173's neurological checks with the director of nursing (DON) identified the checks ended the morning of 2/13/24. The checks did not continue until the resident was discharged on [DATE].<br><br>The 2/14/24 at 11:55 a.m. nurse note read discharge instructions were discussed with Resident #173. The resident'scaregiver gathered all the belongings of the resident. The note at discharge did not document the resident'sbruise on her face.<br><br>VI. Staff interviews<br><br>The DON was interviewed on 6/12/24 at 11:58 a.m. The DON said all residents should be assessed after a fall. She said the nurses should complete a risk management assessment and check the resident for injuries. She said if the resident hit their head, staff would complete neurological checks for three days.<br><br>The DON said Resident #173 was at the facility for a short rehabilitation stay. She said the resident was discharged from the facility on 2/14/24. She said the resident fell on [DATE] and was seen by the physician on 2/12/24 and there was no bruising noted to the resident'sface. She said the resident did not have injuries from her fall on 2/10/24 and there were no other falls documented or injuries to the resident'sface identified.<br><br>Certified nurse aide (CNA) #2 was interviewed on 6/12/24 at 1:07 p.m. CNA #2 said she noticed the resident had a bruise under her eye under her eye glasses. She said the bruise was blue in color when she first noticed it. She said the resident told her that she hit her face when she was attempting to transfer from her bed to her scooter and did not want anyone to know she had a bruise. She said the resident did not tell anyone she hit her face. CNA #2 said she reported the bruise to the nurse. The CNA said the bruise started under her eye but then moved down one side of her face by her cheekbone. She said the bruised area was not protruding and then started to fade yellow.<br><br>(continued on next page) |

| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 065286 | (X2) MULTIPLE CONSTRUCTION A. Building B. Wing | (X3) DATE SURVEY COMPLETED 06/12/2024 |
|---|---|---|---|

| NAME OF PROVIDER OR SUPPLIER | STREET ADDRESS, CITY, STATE, ZIP CODE |
|---|---|
| Eagle Ridge Post Acute | 2425 Teller Ave<br>Grand Junction, CO 81501 |

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

The DON was interviewed again on 6/12/24 at 4:11 p.m. The DON said she interviewed all the nurses and CNAs who worked the night of 2/12/24 and those who called her back did not recall Resident #173 falling outside or any other location. The DON said she contacted Resident #173 on 6/12/24 and the resident told her she had a second fall. She said the resident said she fell when she was outside smoking. The DON said the resident said she yelled out and a CNA came outside to find her on the ground. She said the resident said she begged the nurse not to report the fall.

The DON said the bruise on her face was from the fall outside. The DON said she interviewed CNA #2 who confirmed the bruise was found under the resident's eye prior to discharge. She said CNA #2 reported the injury to the nurse but the nurse did not notify the DON of the reported bruise. The DON said there was no documentation to show the resident was assessed after the resident fell outside or after a bruise on the resident'sface was identified.

The DON said the nurse should have reported the incident and injury to the DON, assessed the resident and documented the fall and injury. The DON said she needed staff to report any incident so the facility could determine the next follow-up action and interventions and notify the physician and family. She said she would follow-up and complete an education with the nurses and the CNAs to report all incidents to the DON and would educate them on the importance of reporting incidents.

The DON said she would inform her staff that it was important to timely assess residents after an incident to ensure resident safety and ensure there was no head trauma and the completion of neurological checks. She said staff needed to completely assess the resident to know all the circumstances associated with the fall/and or injuries, monitor for injuries and create interventions to help prevent future falls. The DON said if she had been made aware the resident'scushion slipped/moved from her scooter seat, a non-slip material could have been placed under the seat.

The DON said all of the residents were supervised smokers. She said there was a breakdown in the smoking policy. She said the resident should not have been smoking outside alone. She said all of the residents should have their cigarettes in a locked box with the nurse. She said she was not sure if the resident had cigarettes in her room not locked up or if she got the cigarettes from the nurse who knew she went outside to smoke. The DON said the resident told her she did not know if staff knew she went outside to smoke when she fell . The DON said, starting 6/13/24, all staff and resident smokers would be re-educated on the smoking policy and the risk of not following the smoking policy. She said the risk of staff and residents not following the smoking policy could result in burns, falling if the resident attempted to pick up a fallen cigarette and the risk of a fire. The DON said the education would also include agency staff and would be continued with all new hire staff during orientation.

VII. Facility follow-up

The facility initiated fall investigation was provided by the DON on 6/12/24 at approximately 4:30 p.m. The investigation included a 6/12/24 interview with CNA #2, an interview with Resident #173 and a list of staff she contacted or attempted to contact who worked the night shift around the approximate time the resident had a second fall or report of injury.

(continued on next page)

| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 065286 | (X2) MULTIPLE CONSTRUCTION A. Building B. Wing | (X3) DATE SURVEY COMPLETED 06/12/2024 |
|---|---|---|---|

| NAME OF PROVIDER OR SUPPLIER | STREET ADDRESS, CITY, STATE, ZIP CODE |
|---|---|
| Eagle Ridge Post Acute | 2425 Teller Ave<br>Grand Junction, CO 81501 |

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<br><br>Level of Harm - Minimal harm or potential for actual harm<br><br>Residents Affected - Few | The DON's interview with Resident #173 read the resident fell four days or so prior to her discharge. The resident said she went out to the courtyard at 1:00 a.m. or 2:00 a.m. Her cushion on her scooter slipped. According to the documented interview, the resident started to yell and a CNA came outside and found her. The CNA then got a nurse. The resident did not know the name of the nurse but was able to describe her.<br><br>A 6/12/24 witness statement from CNA #2 read CNA #2 entered Resident #173's room. The resident had glasses on and when she turned her head CNA #2 noticed a bruise on the side of her face. According to the statement, CNA #2 asked the resident what happened and the resident told her she hit her head while transferring. CNA #2 asked the resident if the nurse was aware and the resident said no. CNA #2 left the room and reported the incident to the nurse on duty. CNA #2 did not recall who she reported the incident to.<br><br>The list of staff the DON contacted documented the staff who returned the DON's call did not recall the incident, injury or CNA #2 reporting a bruise.<br><br>The staff education on safe resident smoking and smoking policy, conducted on 6/14/24 and 6/17/24, was provided by the NHA on 6/17/24 at 2:36 p.m. via email. According to the provided education, 36 staff members received education on the smoking policy, resident smoking times, and safe smoking standards at the facility to include:<br><br>-Residents must be supervised by a staff member;<br><br>-Residents were not allowed to smoke outside of smoking times unless accompanied by family or a friend; and,<br><br>-The cigarettes and lighters were to remain in a locked box at the nurses station and a staff member would light the cigarette for the residents. |

| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 065286 | (X2) MULTIPLE CONSTRUCTION A. Building B. Wing | (X3) DATE SURVEY COMPLETED 06/12/2024 |
|---|---|---|---|

| NAME OF PROVIDER OR SUPPLIER | STREET ADDRESS, CITY, STATE, ZIP CODE |
|---|---|
| Eagle Ridge Post Acute | 2425 Teller Ave<br>Grand Junction, CO 81501 |

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 0692

Level of Harm - Actual harm

Residents Affected - Few

Provide enough food/fluids to maintain a resident's health.

**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 50314

Based on observations, record review and interviews, the facility failed to ensure one (#54) of five residents out of 45 sample residents received the care and services necessary to meet their nutrition needs and to maintain their highest level of physical well-being.

Resident #54 was admitted to the facility for long term care on 11/10/23 with diagnoses of chronic obstructive pulmonary disease (COPD), diabetes and generalized muscle weakness. The resident was initially weighed on 11/19/23 and weighed 149 pounds (lbs).

The resident was admitted to the hospital from 1/2/24 to 1/8/24 for electrolyte imbalances. Upon readmission to the facility the resident weighed 135.2 lbs. On 1/22/24 and 1/29/24 the resident weighed 123.6 lbs. On 2/5/24 the resident weighed 123 lbs. The resident sustained a 26 lbs (17.4%) weight loss in three months and 12.2 lbs (9%) in one month, which was considered severe weight loss.

The facility failed to assess the resident and implement nutrition interventions after the resident sustained severe weight loss on 2/5/24. The facility did not weigh the resident after she sustained severe weight loss, despite the registered dietitian (RD) requesting the resident to be weighed.

Findings include:

I. Facility policy and procedure

The nutritional assessment policy, revised October 2017, was provided by the nursing home administrator (NHA) on 6/11/24 at 3:14 p.m. It documented in pertinent part:

The dietitian, in conjunction with the nursing staff and healthcare practitioners, will conduct a nutritional assessment for each resident upon admission (within current baseline assessment timeframes) and as indicated by a change in condition that places the resident at risk for impaired nutrition.

Once current conditions and risk factors for impaired nutrition are assessed and analyzed, individual care plans will be developed that address or minimize to the extent possible the resident' s risks for nutritional complications. Such interventions will be developed within the context of the resident' s prognosis and personal preferences

II. Resident #54

A. Resident status

Resident #54, over the age of 65, was admitted to the facility on [DATE] and readmitted on [DATE]. According to the June 2024 computerized physician orders (CPO), diagnoses included COPD, diabetes type II and generalized muscle weakness.

(continued on next page)

| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 065286 | (X2) MULTIPLE CONSTRUCTION A. Building B. Wing | (X3) DATE SURVEY COMPLETED 06/12/2024 |
|---|---|---|---|

| NAME OF PROVIDER OR SUPPLIER | STREET ADDRESS, CITY, STATE, ZIP CODE |
|---|---|
| Eagle Ridge Post Acute | 2425 Teller Ave Grand Junction, CO 81501 |

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 0692

Level of Harm - Actual harm

Residents Affected - Few

The 4/9/24 minimum data set (MDS) assessment revealed the resident had moderate cognitive impairment with a brief interview for mental status (BIMS) score of 11 out of 15. The resident required set-up or clean-up assistance with eating. The resident required substantial or maximum assistance with transfers, showers, toileting and personal hygiene.

The assessment documented the resident was 64 inches (5 foot, 4 inches) tall.

The assessment did not indicate the residents weight. It documented the resident had not had any significant weight loss or weight gain.

-However, the resident had sustained a 26 lbs (17.4%) weight loss in three months and 12.2 lbs (9%) in one month, which was considered severe weight loss.

B. Resident interview

Resident #54 was interviewed on 6/6/24 at 9:41 a.m. Resident #54 said she preferred to eat in her room with her roommate. Resident #54 said she was served scrambled eggs for breakfast several times per week and she did not like them because of how bland they were. Resident #54 said she sent her breakfast back several times each week because of how bland the scrambled eggs were. Resident #54 said she had lost weight because of this. Resident #54 said she skipped several meals throughout the week because she did not like to eat the bland eggs. Resident #54 said she often felt very hungry by lunch time.

C. Observations

On 6/10/24 at 8:12 a.m., Resident #54 was observed to have a breakfast tray on her bedside table. The breakfast had been consumed except for scrambled eggs that were untouched on the breakfast tray.

D. Record review

The nutrition care plan, initiated on 11/21/23 and revised on 11/28/23, documented the resident was at a minimal nutritional risk with consistent food intake greater than 50%. The care plan documented the resident would be offered nutrition for comfort and pleasure while the resident was receiving hospice services. The interventions included monitoring the resident' s intake, obtaining weights as ordered, completing an assessment by the RD and monitoring the resident' s skin for signs of breakdown.

-However, a review of the resident' s electronic medical record (EMR) did not reveal the resident was receiving hospice services.

-A review of the comprehensive care plan did not reveal documentation indicating new interventions were implemented after the resident sustained severed weight loss on 2/5/24.

The 11/14/23 dietary pre-screen assessment documented the resident liked fried and poached eggs and spicy foods.

The resident was hospitalized on [DATE], and readmitted to the facility on [DATE] for electrolyte imbalances.

(continued on next page)

| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 065286 | (X2) MULTIPLE CONSTRUCTION A. Building B. Wing | (X3) DATE SURVEY COMPLETED 06/12/2024 |
|---|---|---|---|
| NAME OF PROVIDER OR SUPPLIER: Eagle Ridge Post Acute | | STREET ADDRESS, CITY, STATE, ZIP CODE: 2425 Teller Ave Grand Junction, CO 81501 | |

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 0692<br><br>Level of Harm - Actual harm<br><br>Residents Affected - Few | The December 2023 CPO revealed Resident #54 was to be weighed weekly for four weeks on Friday mornings, initiated on 11/17/23 and discontinued on 12/8/23.<br><br>The June 2024 CPO revealed the resident had a physician' s order to be weighed weekly for four weeks, every Monday, ordered 1/15/24 and discontinued on 2/6/24.<br><br>Resident #54' s weights were documented in the EMR as follows:<br><br>-On 11/19/23, the resident weighed 149 lbs;<br><br>-On 1/8/24, the resident weighed 135.2 lbs;<br><br>-On 1/22/24, the resident weighed 123.6 lbs;<br><br>-On 1/29/24, the resident weighed 123.6 lbs; and,<br><br>-On 2/5/24, the resident weighed 123 lbs.<br><br>-The resident lost 12.2 lbs (9%) from 1/8/24 to 2/5/24, in one month, which was considered severe.<br><br>-The resident lost 26 lbs (17.4%) from 11/19/23 to 2/5/24, in three months, which was considered severe.<br><br>-No additional physician orders to obtain weight were documented in the resident' s EMR. The facility had not obtained the resident' s weight in more than four months between 2/6/24 and 6/11/24 after this significant weight loss was documented.<br><br>A review of the certified nurse aide (CNA) task response history (from 5/15/24 to 6/11/24) revealed staff had documented the amount the resident had eaten for 51 out of 81 meal opportunities during the review period.<br><br>-There were no documented resident refusals for meals. It was documented the resident ate less than 50% of her meals for two of 51 documented meals.<br><br>The 6/11/24 nutrition progress note documented the resident was last weighed on 2/5/24 when the resident weighed 123 pounds.<br><br>IV. Staff interviews<br><br>Licensed practical nurse (LPN) #1 was interviewed on 6/10/24 at 8:42 a.m. LPN #1 said he had seen the kitchen serve Resident #54' s scrambled eggs. He said when this occurred he would ask the kitchen for different eggs.<br><br>LPN #6 was interviewed on 6/12/24 at 10:29 a.m. LPN #6 said there was not a current physician' s order to weigh Resident #54 weekly or monthly. LPN #6 said nursing staff followed the physician' s order for obtaining the resident's weights. She said a nurse could request to weigh a resident if there was a weight concern identified by nursing staff.<br><br>(continued on next page) |

| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 065286 | (X2) MULTIPLE CONSTRUCTION A. Building B. Wing | (X3) DATE SURVEY COMPLETED 06/12/2024 |
|---|---|---|---|
| NAME OF PROVIDER OR SUPPLIER Eagle Ridge Post Acute | | STREET ADDRESS, CITY, STATE, ZIP CODE 2425 Teller Ave Grand Junction, CO 81501 | |

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 0692<br><br>Level of Harm - Actual harm<br><br>Residents Affected - Few | The RD was interviewed on 6/12/24 at 11:47 a.m. The RD said the facility did not have a current weight for Resident #54. The RD said she was concerned about the facility using different scales from January 2024 to February 2024 to weigh the resident.<br><br>The RD said she had verbally requested the nursing staff to obtain additional weights. The RD said she did not document when she requested to have the resident reweighed after 2/5/24. The RD said she did not know why the significant weight loss was not identified or followed up on. The RD said new interventions should have been identified when Resident #54 sustained significant weight loss to prevent further weight loss.<br><br>The director of nursing (DON) was interviewed on 6/12/24 at 1:05 p.m. The DON said Resident #54 experienced significant weight loss and the facility did not identify it. The DON said no new nutrition interventions were implemented to prevent further weight loss after 2/5/24. The DON said no new weights were obtained for Resident #54 after she sustained severe weight loss on 2/5/24.<br><br>The DON said Resident #54 should have had her significant weight loss identified in her plan of care and more weights should have been obtained after 2/5/24 to monitor the resident' s status. The DON said the facility could have offered a nutritional supplement, such as a Mighty shake (frozen nutritional supplement), to help maintain Resident #54' s weight. The DON said she was not aware of any inaccurate scales in the facility.<br><br>The DON was interviewed again on 6/12/24 at 4:32 p.m. The DON said the quality assurance and performance improvement (QAPI) committee had identified that the facility had an issue obtaining and documenting weights in the facility within the last few months, but had not implemented a correction plan. The DON said she needed to work with the RD to ensure residents were getting weighed on a regular basis. The DON said she needed to review weight loss interventions in the facility to ensure they were being updated and documented. |

| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 065286 | (X2) MULTIPLE CONSTRUCTION A. Building B. Wing | (X3) DATE SURVEY COMPLETED 06/12/2024 |
| --- | --- | --- | --- |

| NAME OF PROVIDER OR SUPPLIER | STREET ADDRESS, CITY, STATE, ZIP CODE |
| --- | --- |
| Eagle Ridge Post Acute | 2425 Teller Ave<br>Grand Junction, CO 81501 |

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 0804

Level of Harm - Minimal harm or potential for actual harm

Residents Affected - Some

Ensure food and drink is palatable, attractive, and at a safe and appetizing temperature.

48412

Based on observations, record review and interviews, the facility failed to ensure residents consistently received food prepared by methods that conserve nutritive value, palatable in taste, texture, appearance and temperature.

Specifically, the facility failed to ensure food was served palatable, attractive and served at the appropriate temperature.

Findings include:

I. Resident interviews

Resident #4 was interviewed on 6/5/24 at 10:25 a.m. Resident #4 said the food was not always good. Resident #4 said the food was under seasoned at times and sometimes he received his meal cold.

Resident #22 was interviewed on 6/5/24 at 11:00 a.m. Resident #22 said the food was awful and tasted bad. He said he ate his meals in his room and the food was delivered to him cold. Resident #22 said the food looked how it tasted. He said the food was undercooked and over-seasoned.

Resident #57 was interviewed on 6/5/24 at 3:35 p.m. Resident #57 said the food was awful and his lunch on 6/5/24 had no seasoning to it. The resident said his food was normally bland and he did not like to eat it.

Resident #17 was interviewed on 6/6/24 at 9:20 a.m. Resident #17 said the quality of the food was not good. He said the food was processed and bland.

Resident #54 was interviewed on 6/6/24 at 11:36 a.m. Resident #54 said she skipped several meals a week because the food did not taste good.

II. Observations

A test tray for a regular diet was evaluated by three surveyors immediately after the last resident had been served their room tray for lunch on 6/10/24 at 12:51 p.m.

The test tray consisted of spaghetti and meatballs, lima beans, garlic toast and chocolate pudding.

-The spaghetti and meatballs were 130 degrees Fahrenheit (F);

-The lima beans were 103 degrees F and mushy and bland. The lima beans appeared gray and were not a vibrant green;

-The garlic toast was overcooked and hard, chewy and salty. The garlic toast appeared partially burnt; and,

(continued on next page)

| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 065286 | (X2) MULTIPLE CONSTRUCTION A. Building B. Wing | (X3) DATE SURVEY COMPLETED 06/12/2024 |
|---|---|---|---|

| NAME OF PROVIDER OR SUPPLIER | STREET ADDRESS, CITY, STATE, ZIP CODE |
|---|---|
| Eagle Ridge Post Acute | 2425 Teller Ave Grand Junction, CO 81501 |

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 0804<br><br>Level of Harm - Minimal harm or potential for actual harm<br><br>Residents Affected - Some | -The chocolate pudding was 54.5 degrees F and did not feel cold.<br><br>III. Staff interviews<br><br>The dietary director (DD) and the nursing home administrator (NHA) were interviewed together on 6/12/24 at 1:17 p.m. The DD said the pudding cups were prepared, portioned out and placed in the walk-in refrigerator until it was time to serve. The DD said the pudding should have been stored on ice during the meal service to help maintain the correct temperature since the pudding was made with dairy products.<br><br>The DD said cold foods needed to be served below 41 degrees F. The DD said the containers of pudding on the counter were going to be thrown away at the end of the meal service, since they had not been held at the correct temperature. The DD said he wanted the residents to receive the hot foods at 135 degrees F and the hot boxes were set to 135 degrees F.<br><br>The NHA said more education would be provided and the facility had started a food committee for the residents on 6/12/24 (during the survey). The NHA said the residents' feedback from the food committee was going to help improve the food. |

| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 065286 | (X2) MULTIPLE CONSTRUCTION A. Building B. Wing | (X3) DATE SURVEY COMPLETED 06/12/2024 |
|---|---|---|---|
| NAME OF PROVIDER OR SUPPLIER Eagle Ridge Post Acute | | STREET ADDRESS, CITY, STATE, ZIP CODE 2425 Teller Ave Grand Junction, CO 81501 | |

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 0880<br><br>Level of Harm - Minimal harm or potential for actual harm<br><br>Residents Affected - Many | Provide and implement an infection prevention and control program.<br><br>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 50314<br><br>Based on observations, record review and interviews, the facility failed to maintain an infection control program designed to provide a safe, sanitary and comfortable environment to help prevent the possible development and transmission of infectious diseases.<br><br>Specifically, the facility failed to:<br><br>-Ensure housekeeping staff changed gloves and performed hand hygiene consistently when appropriate during resident room cleaning;<br><br>-Ensure housekeeping staff properly used a disinfectant chemical per manufacturer's instructions when cleaning resident rooms;<br><br>-Ensure staff donned (put on) the appropriate personal protective equipment (PPE) when providing direct care to residents on enhanced barrier precautions (EBP);<br><br>-Ensure a process was in place to ensure staff were aware of which residents required EBP;<br><br>-Provide clean linens after performing wound care and a wound dressing change;<br><br>-Offer hand hygiene to residents before meals; and,<br><br>-Implement an effective water management plan.<br><br>Findings include:<br><br>I. Housekeeping failures<br><br>A. Facility policy and procedure<br><br>The Infection Prevention and Control Program policy, revised October 2018, was received from the nursing home administrator (NHA) on 6/10/24 at 10:24 a.m. It documented in pertinent part,<br><br>Policies and procedures reflect the current infection prevention and control standards of practice.<br><br>Important facets of infection prevention include educating staff and ensuring that they adhere to proper techniques and procedures, implementing appropriate isolation precautions when necessary, and following established general and disease-specific guidelines such as those of the Centers for Disease Control (CDC).<br><br>The Hand Hygiene policy, revised October 2023, was provided by the nursing home administrator (NHA) on 4/12/24 at 2:59 p.m. It read in pertinent part:<br><br>All personnel are trained and regularly in-serviced on the importance of hand hygiene in preventing the transmission of healthcare-associated infections.<br><br>(continued on next page) |

| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 065286 | (X2) MULTIPLE CONSTRUCTION A. Building B. Wing | (X3) DATE SURVEY COMPLETED 06/12/2024 |
|---|---|---|---|
| NAME OF PROVIDER OR SUPPLIER Eagle Ridge Post Acute | | STREET ADDRESS, CITY, STATE, ZIP CODE 2425 Teller Ave Grand Junction, CO 81501 | |

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 0880<br><br>Level of Harm - Minimal harm or potential for actual harm<br><br>Residents Affected - Many | All personnel are expected to adhere to hand hygiene policies and practices to help prevent the spread of infections to other personnel, residents and visitors.<br><br>Hand hygiene is indicated immediately before touching a resident, before performing an aseptic task, after contact with blood, bodily fluids, or contaminated surfaces, after touching a resident, after touching a resident's environment, before moving from work on a soiled body site to a clean body site on the same resident; and immediately after glove removal.<br><br>The Centers for Disease Control and Prevention (CDC) Environment Cleaning Procedures, (revised 3/19/24) was retrieved on 6/20/24 from https://www.cdc.gov/healthcare-associated-infections/hcp/cleaning-global/appendix-c.html. It read in pertinent part,<br><br>High-Touch Surfaces: The identification of high-touch surfaces and items in each patient care area is a necessary prerequisite to the development of cleaning procedures, as these will often differ by room, ward and facility.<br><br>Common high-touch surfaces include: bed rails, IV (intravenous) poles, sink handles, bedside tables, counters, edges of privacy curtains, patient monitoring equipment (keyboards, control panels), call bells and door knobs.<br><br>Proceed from cleaner to dirtier areas to avoid spreading dirt and microorganisms. Examples include: during terminal cleaning, clean low-touch surfaces before high-touch surfaces, clean patient areas (patient zones) before patient toilets, within a specified patient room, terminal cleaning should start with shared equipment and common surfaces, then proceed to surfaces and items touched during patient care that are outside of the patient zone, and finally to surfaces and items directly touched by the patient inside the patient zone. In other words, high-touch surfaces outside the patient zone should be cleaned before the high-touch surfaces inside the patient zone and clean general patient areas not under transmission-based precautions before those areas under transmission-based precautions.<br><br>B. Manufacturer's guidelines for Diffense disinfecting cleaner<br><br>The Diffense disinfecting cleaner instructions were retrieved from https://www.spartanchemical.com/products/product/102403#top on 6/18/24. It read in pertinent part:<br><br>Diffense offers 60-second disinfection for most common bacteria and viruses.<br><br>Diffense kills clostridium difficile (C-diff) in 8 (eight) minutes.<br><br>C. Observations<br><br>On 6/10/24 at 10:18 a.m. housekeeper (HSKP) #2 was observed cleaning room [ROOM NUMBER]. HSKP #2 sprayed high-touch surfaces with Diffense disinfecting cleaner. While spraying high-touch surfaces, HSKP #2 touched the toilet seat with gloved hands. HSKP #2 then cleaned the sink and mirror.<br><br>(continued on next page) |

| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 065286 | (X2) MULTIPLE CONSTRUCTION A. Building B. Wing | (X3) DATE SURVEY COMPLETED 06/12/2024 |
|---|---|---|---|
| NAME OF PROVIDER OR SUPPLIER: Eagle Ridge Post Acute | | STREET ADDRESS, CITY, STATE, ZIP CODE: 2425 Teller Ave Grand Junction, CO 81501 | |

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 0880<br><br>Level of Harm - Minimal harm or potential for actual harm<br><br>Residents Affected - Many | After cleaning the sink and mirror, HSKP #2 changed her gloves and performed hand hygiene. HSKP #2 then donned new gloves and began cleaning the door and cabinet handles. HSKP #2 sprayed the door and cabinet handles with Diffense disinfecting spray, then immediately wiped the wet spray off with a dry cloth.<br><br>-The call light cord in the bathroom was not touched or cleaned by HSKP #2 during the room cleaning process.<br><br>-HSKP #2 failed to change gloves and perform hand hygiene after touching the toilet seat before cleaning the sink and mirror.<br><br>-HSKP #2 failed to allow the disinfectant to remain on surfaces for the manufacturer's recommended dwell time to ensure effective disinfection.<br><br>-HSKP #2 failed to clean the room call light cord.<br><br>On 6/11/24 at 10:12 a.m. HSKP #3 was observed cleaning room [ROOM NUMBER]. HSKP #3 was observed to spray Diffense disinfecting cleaner on the room's door handles before immediately wiping off the wet spray with a dry cloth.<br><br>-The call light cord in the bathroom was not touched or cleaned by HSKP #3 during the room cleaning process.<br><br>-HSKP #3 failed to allow the disinfectant to remain on surfaces for the manufacturer's recommended dwell time to ensure effective disinfection.<br><br>D. Staff interviews<br><br>HSKP #2 was interviewed on 6/10/24 at 10:38 a.m. HSKP #2 said she was not fluent in the English language, and this created a communication barrier between both spanish-speaking housekeepers and administrative staff. HSKP #2 said Diffense disinfecting cleaner required one minute to kill most bacteria and viruses, and required three minutes to kill clostridium difficile.<br><br>-However, according to the manufacturer's guideline, the disinfectant required eight minutes to kill clostridium difficile (see manufacturer's guidelines above).<br><br>HSKP #2 said she had not left the Diffense disinfecting spray on the door and cabinet handles for long enough before wiping it off with a dry cloth. HSKP #2 said gloves must be changed in between contaminated surfaces. HSKP #2 said she had not received training in the facility for how to clean rooms in her preferred language because her supervisors did not speak Spanish.<br><br>HSKP #3 was interviewed on 6/11/24 at 10:11 a.m. HSKP #3 said she was not fluent in the English language, and this created a communication barrier between the housekeeping staff and all other staff who only spoke English. HSKP #3 said the Diffense disinfecting cleaner had a 60-second dwell time to kill bacteria. HSKP #3 said she did not allow the disinfectant to dwell for 60 seconds before wiping it off with a cloth. HSKP #3 said she had not received training on how to clean a room from her supervisor in her preferred language.<br><br>(continued on next page) |

| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 065286 | (X2) MULTIPLE CONSTRUCTION A. Building B. Wing | (X3) DATE SURVEY COMPLETED 06/12/2024 |
|---|---|---|---|
| NAME OF PROVIDER OR SUPPLIER Eagle Ridge Post Acute | | STREET ADDRESS, CITY, STATE, ZIP CODE 2425 Teller Ave Grand Junction, CO 81501 | |

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 0880<br><br>Level of Harm - Minimal harm or potential for actual harm<br><br>Residents Affected - Many | The NHA was interviewed on 6/11/24 at 2:04 p.m. The NHA said she was currently acting in the role of the housekeeping supervisor. The NHA said housekeepers should change their gloves and perform hand hygiene after touching a resident's toilet. The NHA said housekeepers should allow enough time for the Diffense disinfectant solution to properly disinfect the high touch surface areas before wiping off the disinfectant. The NHA said door handles, call lights, and cabinet handles were considered high-touch areas that should be disinfected every day to prevent the spread of infection.<br><br>II. Enhanced barrier precautions (EBP)<br><br>A. Facility policy and procedure<br><br>The Enhanced Barrier Precautions policy, undated, was received from the NHA on 6/10/24 at 10:24 a.m. It documented in pertinent part,<br><br>All staff receive training on enhanced barrier precautions upon hire and at least annually and are expected to comply with all designated precautions.<br><br>Clear signage will be posted on the door or wall outside of the resident room indicating the type of precautions, required personal protective equipment (PPE), and the high-contact resident care activities that require the use of gown and gloves.<br><br>Nursing staff may place residents with certain conditions or devices on enhanced barrier precautions empirically while awaiting physician orders.<br><br>Make gowns and gloves available immediately outside of the resident's room.<br><br>The infection preventionist will incorporate periodic monitoring and assessment of adherence to determine the need for additional training and education.<br><br>The Personal Protective Equipment policy, dated October 2018, was received from the NHA on 6/10/24 at 10:24 a.m. It documented in pertinent part, PPE required for transmission-based precautions is maintained outside and inside the resident's room, as needed.<br><br>B. Record review<br><br>According to the EMR of Resident #19 (admitted [DATE]), the resident had an ostomy, which necessitated EBP to be identified and PPE to be worn during direct care of the resident.<br><br>According to the EMR of Resident #16 (admitted [DATE]), the resident had a wound and a catheter, which necessitated EBP to be identified and PPE to be worn during direct care of the resident.<br><br>According to the EMR of Resident #34 (admitted [DATE]), the resident had a catheter, which necessitated EBP to be identified and PPE to be worn during direct care of the resident.<br><br>C. Observations<br><br>On 6/10/24 at 10:31 a.m. licensed practical nurse (LPN) #1 was observed assisting Resident #19 to the bathroom without wearing PPE.<br><br>(continued on next page) |

| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 065286 | (X2) MULTIPLE CONSTRUCTION A. Building B. Wing | (X3) DATE SURVEY COMPLETED 06/12/2024 |
|---|---|---|---|
| NAME OF PROVIDER OR SUPPLIER Eagle Ridge Post Acute | | STREET ADDRESS, CITY, STATE, ZIP CODE 2425 Teller Ave Grand Junction, CO 81501 | |

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 0880<br><br>Level of Harm - Minimal harm or potential for actual harm<br><br>Residents Affected - Many | On 6/10/24 at 4:19 p.m., an unidentified staff member was observed assisting Resident #16 without wearing PPE. The director of nursing observed this with the survey team. (see interview below)<br><br>On 6/10/24 at 9:27 p.m. LPN #8 was observed assisting Resident #16 with eating and drinking without wearing PPE.<br><br>On 6/10/24 at 9:39 p.m. LPN #8 was observed assisting Resident #34 to the bathroom in his room without wearing PPE.<br><br>D. Staff interviews<br><br>CNA # 2 was interviewed on 6/10/24 at 10:38 a.m. CNA #2 said that she did not know what enhanced barrier precautions were or which residents required PPE for EBP. CNA #2 said if she was unsure if a resident required PPE during care, she would ask a nurse what to do.<br><br>Licensed practical nurse (LPN) #1 was interviewed on 6/10/24 at 11:29 a.m. LPN #1 said that he was unsure if one of the residents identified as needing EBP required contact isolation precautions instead. LPN #1 said that he followed the directions of what was on the isolation door sign when he did wound care. LPN #1 said if a room did not have an isolation type sign on the door, there was no requirement to wear PPE during resident care.<br><br>-However, Resident #19 required PPE for EBP when staff provided direct care for the resident (see observations above).<br><br>The DON was interviewed on 6/10/24 at 4:23 p.m. The DON said the staff member assisting Resident #16 should have been wearing PPE while assisting the resident. She said staff should wear PPE with residents who were on EBP when providing direct care to residents.<br><br>-However, staff members continued to assist residents on EBP without wearing PPE after the DON's interview. (see observations above)<br><br>III. Failure to offer hand hygiene to residents before meals<br><br>A. Observations<br><br>On 6/5/24 at 11:53 a.m. an unidentified resident in a plaid shirt was observed using his hands to wheel himself in his wheelchair to a table in the main dining hall.<br><br>-The resident was not offered hand hygiene before his meal was served.<br><br>On 6/5/24 at 11:55 a.m., Resident #2 was observed using his hand to wheel himself in his wheelchair to the main dining hall.<br><br>-The resident was not offered hand hygiene before his meal was served. The resident ate a hamburger which required the use of his hands.<br><br>On 6/5/24 at 12:03 p.m. Resident #19 was observed using his hands to wheel himself in his wheelchair to the main dining hall.<br><br>(continued on next page) |

| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 065286 | (X2) MULTIPLE CONSTRUCTION A. Building B. Wing | (X3) DATE SURVEY COMPLETED 06/12/2024 |
|---|---|---|---|
| NAME OF PROVIDER OR SUPPLIER Eagle Ridge Post Acute | | STREET ADDRESS, CITY, STATE, ZIP CODE 2425 Teller Ave Grand Junction, CO 81501 | |

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 0880<br><br>Level of Harm - Minimal harm or potential for actual harm<br><br>Residents Affected - Many | -The resident was not offered hand hygiene before his meal was served.<br><br>-On 6/10/24 at 11:58 a.m. residents eating at the table in the common area of the rehabilitation unit were not offered hand hygiene prior to receiving their meal.<br><br>B. Resident Interview<br><br>Resident #5 was interviewed on 6/5/24 at 11:47 a.m. Resident #5 said nursing staff did not normally offer hand hygiene to all residents before meals. Resident #5 said she tried to assist nursing care staff with remembering to offer hand hygiene to residents, but she was unable to watch everyone because she also needs to eat a meal during meal times.<br><br>C. Staff interviews<br><br>Certified nurse aide (CNA) #7 was interviewed on 6/6/24 at 3:14 p.m. CNA #7 said residents should be offered hand hygiene before meals.<br><br>The NHA and the regional operations manager (ROM) were interviewed on 6/12/24 at 4:32 p.m. The NHA said that the facility had not identified hand hygiene as a concern in the facility. The NHA said all staff assisted during meal times with resident trays. The NHA said the facility needed to do more to ensure residents received hand hygiene before meals.<br><br>The ROM said hand hygiene concerns had been discussed among administration several times in the recent past.<br><br>IV. Failure to change soiled bedding after wound dressing change<br><br>A. Observations<br><br>On 6/10/24 at 11:29 a.m. Resident #166's wound dressing change was observed with LPN #1. A draw sheet containing a mixture of blood and yellow drainage was observed under the resident's legs during the wound dressing change.<br><br>After the leg wound dressing changes had been completed by LPN #1, the resident's leg, with the new dressing on it, was placed on top of the old draw sheet containing the old wound drainage. LPN #1 proceeded to doff (remove) his PPE, performed hand hygiene and left the room.<br><br>-Resident #166's bed linens were not appropriately changed after his wound dressing change. (see Resident #166 interview below)<br><br>B. Resident Interview<br><br>Resident #166 was interviewed on 6/11/24 at 1:05 p.m. Resident #166 said no one had changed his soiled draw sheet from 6/10/24 dressing change. Resident #166 volunteered to lift his top bed sheet which exposed a blood and yellow fluid-soaked bed sheet under the resident's legs.<br><br>-The facility failed to change soiled linens for more than 24 hours following a wound dressing change.<br><br>(continued on next page) |

| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 065286 | (X2) MULTIPLE CONSTRUCTION A. Building B. Wing | (X3) DATE SURVEY COMPLETED 06/12/2024 |
|---|---|---|---|
| NAME OF PROVIDER OR SUPPLIER: Eagle Ridge Post Acute | | STREET ADDRESS, CITY, STATE, ZIP CODE: 2425 Teller Ave, Grand Junction, CO 81501 | |

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 0880<br><br>Level of Harm - Minimal harm or potential for actual harm<br><br>Residents Affected - Many | C. Staff interview<br><br>The DON was interviewed on 6/11/24 at 1:14 p.m. The DON said a newly-changed wound dressing should not be placed on dirty linens. The DON said placing a new wound dressing on soiled linens could invite contamination of the wound. The DON said more education was needed in the facility to ensure cleaned wounds were not placed on soiled bed linens.<br><br>V. Failure to have an effective water plan<br><br>A. Facility policy<br><br>The Legionella Water Management Program policy was obtained from the director of maintenance (DM) on 6/11/24 at 2:51 p.m. It documented in pertinent part,<br><br>As part of the infection control program, our facility has a water management program, which is overseen by the water management team.<br><br>The purpose of the water management program is to identify areas in the water system where legionella bacteria can grow and spread, and to reduce the risk of legionnaire's disease.<br><br>The water management program used by our facility is based on the Centers for Disease Control and Prevention and ASHRAE recommendations for developing a legionella water management program.<br><br>B. Record review<br><br>The facility's water management plan was requested from the DM. On 6/11/24 at 2:51 p.m. the DM provided the following information:<br><br>A facility water map which contained hand-drawn lines in pen indicating where water pipes were in the building.<br><br>-The facility failed to assess all locations where legionella and other waterborne pathogens could spread in the facility (see interview below).<br><br>A document which identified the facility had tested for Legionella on 8/23/23 and the test was negative.<br><br>-However, the test was completed as an independent action of the facility and was not a part of a documented full water management plan (see interview below).<br><br>-The documentation provided by the DM failed to include an assessment to identify where Legionella and other opportunistic waterborne pathogens could grow and spread. and<br><br>-Additionally, the documentation failed to identify measures implemented by the facility, such as visible inspections, disinfectant use and water temperature monitoring, to prevent the growth of opportunistic waterborne pathogens and how to monitor the measures.<br><br>C. Staff interviews<br><br>(continued on next page) |

| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 065286 | (X2) MULTIPLE CONSTRUCTION A. Building B. Wing | (X3) DATE SURVEY COMPLETED 06/12/2024 |
|---|---|---|---|

| NAME OF PROVIDER OR SUPPLIER | STREET ADDRESS, CITY, STATE, ZIP CODE |
|---|---|
| Eagle Ridge Post Acute | 2425 Teller Ave<br>Grand Junction, CO 81501 |

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 0880<br><br>Level of Harm - Minimal harm or potential for actual harm<br><br>Residents Affected - Many | The DM and the ROM were interviewed together on 6/11/24 at 3:01 p.m. The DM said he did not know what a water management program was or what elements were required to be in compliance with federal regulations. The DM said the water management program responsibility was given to him a week prior to the survey and he was not given any guidance or training regarding water management programs. The DM said the facility's water systems had been upgraded many times over the years and he did not know where all the water pipes in the facility were. The DM said there could be old pipes with stagnant water in the facility that he did not know about.<br><br>The DM said he knew empty rooms needed to have the water run weekly, but that had not been a problem in the facility as there has not been a vacant room in the facility for seven continuous days.<br><br>The DM said the facility map with hand-drawn lines was provided to demonstrate that he knew where all water pipe access points were in the facility.<br><br>The ROM said the facility did not have a water management program in place currently. The ROM said he understood the facility was not in compliance with water management program requirements. The ROM said that he did not know how to develop a federally-compliant management plan and would research it.<br><br>The ROM was interviewed again on 6/12/24 at 4:32 p.m. The ROM said the Quality Assurance and Performance Improvement (QAPI) committee had not previously identified concerns with the water management program in the facility. |