STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	065286	A. Building B. Wing	08/20/2024

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 0550 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Honor the resident's right to a dignified existence, self-determination, communication, and to exercise his or her rights. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 50314 Based on record review and interviews, the facility failed to ensure care for residents in a manner and in an environment that maintains or enhances each resident's dignity and respect, in full recognition of his or her individuality for one (#1) of five residents reviewed for respect and dignity out of 11 sample residents. Specifically, the facility failed to assist Resident #1, who was dependent on staff for all care, to turn in bed when he requested assistance. Findings include: I. Facility policy and procedure The Resident Rights policy, revised December 2016, was provided by the director of nursing (DON) on 8/22/24 at 11:26 a.m. It read in pertinent part, Federal and state laws guarantee certain basic rights to all residents of this facility. These rights include the resident's right to self-determination, and to be informed of, and participate in, his or her care planning and treatment. II. Resident #1 A. Resident status Resident #1, age less than 65, was admitted on [DATE]. According to the August 2024 computerized physician orders (CPO), diagnoses included complete paraplegia (paralysis below the waist) and incomplete quadriplegia (weakness or paralysis in all four limbs), bipolar disorder, and anxiety disorder. The 7/2/24 minimum data set (MDS) assessment revealed the resident was cognitively intact with a brief interview for mental status (BIMS) score of 15 out of 15 . The MDS assessment indicated Resident #1 had no rejections of care. Resident #1 was dependent upon staff for all activities of daily living (ADL). B. Record review (continued on next page)

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

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F 0550 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	The skin management plan of care, initiated on 2/9/24 and revised on 7/22/24, included interventions to encourage turning and repositioning frequently and as needed and to re-approach the resident at a later time if he refused treatments. Resident #1's behavioral management plan of care, initiated on 11/17/2020 and revised on 7/22/24, included an intervention to give Resident #1 as many choices as possible about his care and activities. A progress note, dated 6/11/24 at 9:18 p.m., documented Resident #1 requested to be turned in bed and the nursing care staff told the resident his next turn was at 10:30 p.m. The progress note documented the nursing care staff told Resident #1 they could not turn the resident every hour as he had requested that evening. The progress note documented that Resident #1 was angry and cursed at the nursing staff when he was told this. A progress note, dated 7/18/24 at 9:42 a.m., documented Resident #1 requested to be left alone when staff attempted to wake the resident. The progress note documented the staff returned with medications to administer to the resident. The progress note documented Resident #1 requested the staff to leave his room again. A progress note, dated 7/18/24 at 9:59 a.m., documented the resident did not respond to the nursing staff when they asked him about his shower preferences. The progress note documented when Resident #1 woke up and was not aggressive with staff he would be informed that the next available shower time to accommodate his preferences would be at 1:00 p.m. A progress note, dated 8/4/24, documented Resident #1 was offered to be turned in bed in the morning and then the resident requested to be turned again at 12:00 p.m. The progress note documented the staff told Resident #1 that it would not be possible to turn him at 12:00 p.m. The progress note documented Resident #1 requested a plan for him to get turned. A progress note, dated 8/13/24, documented Resident #1 was aggravated when the certified nurse aides (CNA) told Resident #1 that there was a time constraint of 25 to 30 minutes on assisting him with repositioning. C. Staff interviews CNA #1 was interviewed on 8/19/24 at 10:07 a.m. CNA #1 said Resident #1 was known to refuse care but the staff needed to work with his preferences to ensure his care was being done. CNA #1 said some of the nursing staff members worked better with Resident #1 than others. CNA #1 said there had been several agency staff members working in the facility and the turnover rate of staff that Resident #1 knew and trusted had affected how often he refused care. CNA #1 said if Resident #1 requested to be turned in bed after refusing other cares, the care requested should be accommodated. CNA #2 was interviewed on 8/19/24 at 10:13 a.m. CNA #2 said Resident #1 was known to be a difficult resident to work with because he occasionally refused care. CNA #2 said the staff were not always able to accommodate Resident #1's requests to be turned in bed because he required maximum assistance of two staff members and often a hoyer lift as well. (continued on next page)

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F 0550 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Licensed practical purse (LPN) #1 was interviewed on 8/20/24 at 1:34 p.m. LPN #1 said he had spoken to Resident #1 about his skin prevention plan of care previously. LPN #1 said Resident #1 felt frustrated when he could not be repositioned when he requested to do so. LPN #1 said Resident #1 had refused cares from him many times in the past and the staff knew to reoffer or reschedule cares for Resident #1 when he refused care. The DON was interviewed on 8/20/24 at 3:14 p.m. The DON said Resident #1 had the right to request to be turned in bed when he wanted to be and this was important to heal his current pressure ulcers as well as prevent future pressure ulcers from occurring. The DON said Resident #1 was known to refuse care for several years. The DON said staff should honor Resident #1's requests for care according to his daily preferences. The DON said it was unacceptable for nursing staff members to tell residents they could not be turned, even if they refused repositioning earlier in the day. The DON said when the residents refused care it should be reoffered often and usually on the same day. The DON said she did not know why the MDS assessment did not accurately record Resident #1's rejection of care.

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F 0760 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure that residents are free from significant medication errors. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 48412 Based on record review and interviews, the facility failed to ensure one (#8) of one resident out of 11 sample residents was free of significant medication errors. Specifically, the facility failed to ensure Resident #8 received her full three-week course of antibiotics as recommended by the hospital. Findings include: I. Professional reference Combating Antibiotic Resistance, reviewed 10/29/19, was retrieved on 8/23/24 from https://www.fda.gov/consumers/consumer-updates/combating-antibiotic-resistance. It read in pertinent part, Antibiotic resistance is a growing public health concern worldwide. In cooperation with other government agencies, the Food and Drug Administration (FDA) has launched several initiatives to address antibiotic resistance. The agency has issued drug labeling regulations, emphasizing the prudent use of antibiotics. The regulations encourage health care professionals to prescribe antibiotics only when clinically necessary, and to counsel patients about the proper use of such drugs and the importance of taking them as directed. It is important to take the medication as prescribed by your doctor, even if you are feeling better. If treatment stops too soon, and you become sick again, the remaining bacteria may become resistant to the antibiotic that you have taken. II. Resident #8 A. Resident status Resident #8, age 77, was admitted on [DATE], discharged on [DATE] and readmitted on [DATE]. According to the August 2024 computerized physician orders (CPO), diagnoses included type 2 diabetes with other diabetic kidney complications, acute osteomyelitis (infection in the bone) of the left ankle and the left foot, encounter for orthopedic aftercare following surgical amputation, sepsis (infection of the blood) and acquired absence of the left great toe. The 8/7/24 minimum data set (MDS) assessment revealed Resident #8 was cognitively intact with a brief interview for mental status (BIMS) score of 13 out of 15. The MDS assessment indicated Resident #8 was receiving antibiotics. B. Record review (continued on next page)

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F 0760 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	The 7/1/24 admission note documented Resident #8 was admitted to the facility with a wound on her left big toe. The wound bed was pink, slough (dead tissue and pus on the surface on the wound) was present and scant (small amount) drainage was noted. The 7/27/24 progress note documented the staff received verbal orders from the physician to send Resident #8 to the emergency room to be evaluated. The 7/28/24 progress note documented the staff called the emergency room and requested an update on the resident's condition. The hospital staff informed the nurse that Resident #8 had been admitted to the hospital. The 7/29/24 hospital operation summary was uploaded to Resident #8's electronic medical record (EMR). It documented the resident had her left great toe amputated due to osteomyelitis. The surgeon documented Resident #8's postoperative plan included three weeks of antibiotics. Resident #8 received intravenous (IV) antibiotics at the hospital and needed to complete oral antibiotics when she discharged from the hospital. The 7/29/24 progress note documented Resident #8 readmitted to the facility. The 8/2/24 nursing progress note documented the nurse received a clarification regarding Resident #8's order for Vancomycin (antibiotic). The facility reached out to the hospital and the dialysis center and determined the dialysis center was going to administer the resident's IV Vancomycin during the resident's dialysis sessions while the facility planned to administer Resident #8's oral Augmentin (antibiotic). The 8/2/24 nursing progress note documented the facility staff spoke with the pharmacist for a STAT (immediate) order of Augmentin. The note documented the pharmacy informed the facility staff that the Augmentin was set to be delivered that same day, on 8/2/24. The 8/2/24 admission note documented the resident had her great toe amputated on 7/29/24. The August 2024 CPO revealed the resident had a physician's order for five milliliters (ml) of Augmentin oral suspension two times a day for 17 days, ordered 8/2/24. The August 2024 medication administration record (MAR) (from 8/1/24 to 8/31/24) documented the resident had an order for five ml of Augmentin twice a day with a start date of 8/2/24 at 7:00 p.m. and an end date of 8/19/24 at 7:00 p.m. -Resident #8 received 26 doses of Augmentin out of the 32 total doses prescribed. On 8/15/24 at 9:17 p.m., a medication administration note documented the facility ran out of the resident's Augmentin. -Review of the resident's EMR did not indicate the physician was notified that the resident missed the dose of Augmentin or that the pharmacy was notified for a refill of the medication. On 8/16/24 at 8:51 a.m., a medication administration note documented the facility ran out of the resident's Augmentin. (continued on next page)

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F 0760 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	-Review of the resident's EMR did not indicate the physician was notified that the resident missed the dose of Augmentin or that the pharmacy was notified for a refill of the medication. On 8/16/24 at 9:15 p.m., a medication administration note documented the facility ran out of the resident's Augmentin. -Review of the resident's EMR did not indicate the physician was notified that the resident missed the dose of Augmentin or that the pharmacy was notified for a refill of the medication. On 8/17/24 at 8:26 a.m., a medication administration note documented the facility ran out of the resident's Augmentin. -Review of the resident's EMR did not indicate the physician was notified that the resident missed the dose of Augmentin or that the pharmacy was notified for a refill of the medication. On 8/17/24 at 7:22 p.m., a medication administration note documented the facility ran out of the resident's Augmentin. -Review of the resident's EMR did not indicate the physician was notified that the resident missed the dose of Augmentin or that the pharmacy was notified for a refill of the medication. The 8/17/24 nursing progress note, documented at 7:59 p.m., revealed the staff called the on-call physician and received an order to hold the resident's Augmentin until Monday 8/19/24. The on-call physician said the staff needed to inform the medical director (MD) on 8/19/24 regarding the discontinuation date for the Augmentin. On 8/18/24 at 9:10 a.m., a medication administration note documented the facility ran out of the resident's Augmentin. -Review of the resident's EMR did not indicate the physician was notified that the resident missed the dose of Augmentin or that the pharmacy was notified for a refill of the medication. III. Staff interviews The medical director (MD) was interviewed on 8/20/24 at 11:29 a.m. The MD said she was unable to recall if Resident #8 received a full course of antibiotics for three weeks as prescribed in her postoperative care. The MD said, after reviewing the resident's EMR, the resident did not receive all of the required doses of the Augmentin. The MD said the facility had a lot of agency staff members who did not understand the process to refill medications. The MD said the antibiotic needed to be administered according to the physician's order. She said she was not informed that the resident was out of the Augmentin. (continued on next page)

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F 0760 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Licensed practical nurse (LPN) #1 was interviewed on 8/20/24 at 1:34 p.m. LPN #1 said the night shift nurses ordered medications that were due to be refilled every Monday, Wednesday and Friday. He said the pharmacy took anywhere from one to three days to deliver the medications, depending on what the medications were. LPN #1 said the facility had a backup medication system in the facility which stocked Augmentin. He said it was concerning that Resident #8 did not receive the antibiotics for seven doses and the director of nursing (DON) should have been informed. LPN #1 said he was unaware the medication was not filled by the pharmacy or that the resident missed doses. The pharmacist (PH) was interviewed on 8/20/24 at 1:41 p.m. The PH said the Augmentin was originally ordered on 8/2/24. She said the pharmacy received a refill request from the facility on 8/14/24 at 9:22 p.m. She said the Augmentin was not filled by the pharmacy and she was unable to explain why because there were no notes documented in the system. LPN #2 was interviewed on 8/20/24 at 2:01 p.m. LPN #2 said the night shift nurses refilled the medications every Monday, Wednesday and Friday. LPN #2 said she knew the facility had a backup medication system which stocked antibiotics. She said if the facility's backup system was out of a medication, the staff filled the medication at a community pharmacy and picked up the medications. She said, although she worked on the hall Resident #8 resided, she said she was unaware the resident was out of her Augmentin or that she missed doses of the antibiotic. The DON was interviewed on 8/20/24 at 3:15 p.m. The DON said the staff needed to call the pharmacy as soon as the first missed dose occurred. She said the facility had stocked medications, including antibiotics, that the staff were able to pull the medication from if the pharmacy was unable to deliver it that day. The DON said the nurse was supposed to contact the pharmacy, call the DON and call or send a fax to the on-call physician if a medication had not been refilled. She said the Augmentin ran out on a Friday during the day shift and the pharmacy would have been able to fill the medication. The DON said she was not informed the medication was out and she was not sure why the pharmacy did not fill the medication when the request was received. The DON said all antibiotic courses needed to be completed to prevent antibiotic resistance and Methicillin-resistant Staphylococcus aureus (MRSA- a staph infection that is resistant to antibiotics). IV. Facility follow-up The DON provided follow-up on 8/22/24 at 11:26 a.m. regarding the missed antibiotics. The follow-up documented the missed doses of the Augmentin was a significant medication error. The DON provided education to all of the nurses and corrective actions to the nurses involved in the seven missed doses. The DON completed an audit to identify if other residents missed doses of medications due to the pharmacy not refilling the medicine or the facility not following up with the pharmacy when medications were not received. The DON said she planned on completing the nurse education by 8/30/24. She said beginning 8/30/24, the DON or designee was going to conduct medication administration audits each week for four weeks then monthly for two months and the audit would be re-evaluated at that point in time. The audits were scheduled to be reviewed monthly in each quality assurance and performance improvement (QAPI) meeting until the committee determined the facility sustained compliance.