

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 02/11/2025
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)
<p>F 0565</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Some</p>	<p>Honor the resident's right to organize and participate in resident/family groups in the facility.</p> <p>40467</p> <p>Based on record review and interviews, the facility failed to ensure prompt action was taken upon the filing of a grievance of a group.</p> <p>Specifically, the facility failed to follow up with residents' concerns regarding call light times.</p> <p>Findings include:</p> <p>I. Facility policy and procedure</p> <p>The Grievance/Complaints, Filing policy, revised April 2017, was provided by the nursing home administrator (NHA) on 2/11/25 at 5:12 p.m. The policy read in pertinent part, Residents and their representatives have the right to file grievances, either orally or in writing, to the facility staff or to the agency designated to hear grievances. The administrator and staff will make prompt efforts to resolve grievances to the satisfaction of residents and/or representatives.</p> <p>Any resident, family member, or appointed resident representative may file a grievance or complaint concerning care, behavior of other residents, staff members, theft of property, or any other concerns regarding his or her stay at the facility.</p> <p>All grievances, complaints or recommendations stemming from resident or family groups concerning resident care issues in the facility will be considered. Actions on such issues will be responded to in writing, including irrational for response.</p> <p>Upon receipt of a grievance and/or complaint, the grievance officer will review, investigate the allegations and submit a written report of such findings to the administrator within seven working days of receiving the agreements and/or complaint.</p> <p>The administrator will review the findings with the grievance officer to determine what corrective actions, if any, need to be taken.</p> <p>The resident, or person filing the grievance and or complaint on behalf of the resident, will be informed verbally and in writing of the findings of the investigation and the actions that would be taken to correct any identified problems.</p> <p>(continued on next page)</p>

Any deficiency statement ending with an asterisk (*) denotes a deficiency which the institution may be excused from correcting providing it is determined that other safeguards provide sufficient protection to the patients. (See instructions.) Except for nursing homes, the findings stated above are disclosable 90 days following the date of survey whether or not a plan of correction is provided. For nursing homes, the above findings and plans of correction are disclosable 14 days following the date these documents are made available to the facility. If deficiencies are cited, an approved plan of correction is requisite to continued program participation.

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE	TITLE	(X6) DATE
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<p>F 0565</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Some</p>	<p>The Resident Council policy, revised April 2017, was provided by the NHA on 2/11/25 at 6:15 p.m. The policy read in pertinent part, A resident council response form will be utilized to track issues and their resolution. The facility department related to any issues will be responsible for addressing the items of concern.</p> <p>II. Resident interviews</p> <p>Resident #1 was interviewed on 2/10/25 at 4:08 p.m. He said he often had to wait 30 to 45 minutes for staff to answer his call light. He said the facility added a float certified nurse aide (CNA) at night but most of his concerns were during the day.</p> <p>Resident #20 was interviewed on 2/11/25 at 1:20 p.m. Resident #20 said that it often took almost an hour to have his incontinent brief change, receive his medication or other needed assistance. He said the biggest concern of lack of timely response was at night and on the weekends. He said he submitted grievances to the staff but nothing has changed and the staff did not tell him what they were going to do to correct his grievances. He said the staff just gave him excuses that they had call offs. He said he kept the originals/or copies of grievances forms that he turned in. Resident #20 retrieved three grievances forms for a clip board next to his bed. The three hand written grievances identified the resident's concerns on long waits to receive care.</p> <p>Resident #19 was interviewed on 2/11/25 at 10:46 a.m. Resident #19 said she was a member of the resident council.</p> <p>She said she was able to do most of her care needs herself but other residents have had problems with long call light waits for staff assistance. She said the facility had a new electronic call light system but staff would go into a resident's room and turn off the call light. She said the staff would tell the resident that they would be back while the resident had to continue to wait.</p> <p>Resident #5 was interviewed on 2/11/25 at approximately 11:00 a.m. Resident #5 said she was a member of the resident council and call lights timeliness was a concern. She said there was not enough staff at night before 10:00 p.m. to meet everyone's needs. She said the residents, including herself, had to wait too long. She said there were some residents that continued to require a lot of the staff's time resulting in the other resident's having to wait awhile for help.</p> <p>III. Grievance forms and interviews</p> <p>Two grievance forms, dated 1/23/25, were provided by the NHA on 2/11/25 at 1:55 p.m One of two grievances identified a concern with the lack of timely staff response:</p> <p>The grievance documented Resident #20 waited 35 minutes for help with his oxygen machine on 1/22/25 at 9:00 p.m.</p> <p>The undated findings notation on the grievance form indicated the resident was spoken to and he said the issue was ongoing. According to the notation, the resident would be followed up with weekly.</p> <p>-The concern related to oxygen was rewritten from original 1/22/25 oxygen grievance that was presented during Resident #20's 2/11/25 interview (see above).</p> <p>(continued on next page)</p>		

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<p>F 0565</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Some</p>	<p>-The grievances provided by the facility on 2/11/25 did not include the other grievances dated 1/23/25 presented by the resident during Resident #20's 2/11/25 interview.</p> <p>Two resident grievance forms written by Resident #20 on 1/23/25 were provided by the NHA on 2/11/25 at 2:10 p.m. The NHA said she spoke to Resident #20 and retrieved the 1/23/25 grievances on 2/11/25 (see interviews below). The grievances indicated the following:</p> <p>The first grievance form indicated Resident #20 documented he had been left to lay in his feces between 30 minutes and one and a half hours before getting his bedding changed on multiple occasions in the past few months.</p> <p>-The undated findings notation on the grievance form indicated the resident was spoken to and he said the issue was ongoing. According to the notation, the resident would be followed up weekly.</p> <p>The second grievance form indicated Resident #20 documented it took two hours and five minutes to answer his call light, get his bed changed and receive his pain medication. Resident #20 wrote there had been multiple times when the call light response took over an hour.</p> <p>-The undated findings notation on the grievance form indicated the resident was spoken to and he said the issue was ongoing. According to the notation, the resident would be followed up with weekly.</p> <p>IV. Resident council minutes</p> <p>The 12/9/24 resident council minutes documented the residents felt it took too long of a wait to get help from staff in the evenings.</p> <p>-The minutes did not include the action or a response to the grievance that the facility would take or did take to address the residents' concern of long waits for help.</p> <p>-Request for the December 2024 action plan/grievance for long waits for help was not provided by the facility.</p> <p>The 1/12/25 resident council minutes documented most of the night shifts should have four CNAs unless there were call offs. According to the minutes, tasks like cleaning wheelchairs and handing out new ice water pitchers should be completed during that time.</p> <p>-The minutes did not identify the scheduling of four CNAs at night, were in response to the resident concern of long waits. The minutes did not identify if the residents felt their concern of long waits for help from the 12/9/24 meeting were resolved.</p> <p>V. Frequent visitor interview</p> <p>A frequent visitor was interviewed on 2/10/25 at 3:37 p.m. He said the residents have had an ongoing unresolved concern regarding timely staff assistance on nights and weekends.</p> <p>VI. Electronic call light log</p> <p>(continued on next page)</p>		

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<p>F 0565</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Some</p>	<p>The call light alarm log between 1/11/25 to 2/11/25 was provided by the NHA on 2/11/25 at 3:16 p.m. A sample of the call lights were reviewed for Resident #20, Resident #1 and Resident #5. The log identified the following before the call light was shut off:</p> <p>The call light alarm log indicated for Resident #20 that seven call light response times were between 15 minutes and 20 minutes; five call light response times were between 20 and 30 minutes; and two call lights were 40 minutes or more before the call lights were turned off.</p> <p>-On 1/21/25 at 5:13 p.m. Resident #20's call light response time was logged at 46 minutes.</p> <p>-On 1/22/25 at 8:10 p.m. Resident #20's call light response time was logged at 40 minutes.</p> <p>The call light alarm log indicated for Resident #1 that 51 call light response times were between 15 minutes and 20 minutes; 50 call light response times were between 20 and 30 minutes; 16 call lights were between 30 minutes and 40 minutes; and three call lights were 40 minutes or more before the call lights were turned off.</p> <p>-On 1/12/25 at 4:56 a.m. the call light was on for 40 minutes before the call light was turned off.</p> <p>-On 2/3/25 at 9:46:15 p.m the call light was on for 41 minutes before the call lights were turned off.</p> <p>-On 2/4/25 at 6:23:49 p.m. the call light was on for 41 minutes before the call lights were turned off.</p> <p>The call light alarm log indicated for Resident #5 that 10 call light response times were between 15 minutes and 20 minutes; 15 call light response times were between 20 and 30 minutes; and one call light was between 30 minutes and 40 minutes before the call lights were turned off.</p> <p>-On 1/31/25 at 9:29 p.m. Resident #5's call light was 38 minutes long before it was turned off.</p> <p>VII. Facility education</p> <p>A 12/12/24 and 12/14/24 nurse and CNA meeting agenda was provided by the director of nursing (DON) on 2/11/25 at 12:19 p.m. The agenda identified the CNAs should do at least a two hour rounding of rooms offering care such as toileting and checking and changing the resident. The agenda also identified the 2:00 p.m. to 10:00 p.m. shift and the 4:00 p.m. to 10:00 p.m. shift should assist on the floor while the day and night shift completes their charting.</p> <p>According to the agenda the 2:00 p.m. and 4:00 p.m. shift should answer call lights, stock rooms, pass water and ensure the residents were cared for.</p> <p>-The agenda did not identify education on call light timeliness or interventions to improve call light timeliness in response to the December 2024 resident council concern for long waits for help.</p> <p>VIII. Staff interview</p> <p>(continued on next page)</p>		

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<p>F 0565</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Some</p>	<p>The NHA was interviewed on 2/11/25 at 1:55 p.m. The NHA said she could only find two grievances for Resident #20, a food concern and one regarding him having to wait for 35 minutes for his oxygen to be refilled. She said she had not seen any other grievances dated 1/22/25 and 1/23/25 for delayed care. The NHA said the grievances she received for him were likely rewritten by staff because he might have used inappropriate language. She said she would look for the other grievances again but if she could not find them, she would ask him for his copies.</p> <p>The NHA was interviewed again on 2/11/25 at 2:10 p.m. She said she could not find the grievances in question so she asked the resident for his copies of the grievances on the delayed care concerns. She said she added the findings statement (see record review above) after receiving the grievances copies today (2/11/25).</p> <p>The NHA said she asked Resident #20 which staff member he originally handed the grievance forms to but he could not recall who but he turned them in to someone. She said she did not know why the grievances were not provided to her after he submitted them. She said she would immediately educate the staff on who to turn the grievances into when they receive them from a resident.</p> <p>The NHA was interviewed again on 2/11/25 at 3:36 p.m. The NHA said she reviewed Resident #20 and Resident #1's call light response times from the electronic call light log and said the response times were too long. The NHA said in January 2025 she started a call light look back for one week per month to review the average time of call light responses. She said she had looked at average times as a whole but she did not look at individual rooms to identify individual resident call light response times.</p> <p>The social service director (SSD) was interviewed on 2/11/25 at 4:14 p.m. The SSD said if a staff member received a grievance from a resident, they should have turned the grievance form into her box in the copy room, slid it under her office door or personally handed it to her. She said when she received a grievance, she would log it to track it and then hand it to the appropriate department the grievance pertained to. She said the department identified had seven days to rectify the grievance. The SSD said the resident would be followed up with after 14 days of submitting the grievance to give a seven day opportunity for the action taken to attempt to rectify the grievance, to take effect. The SSD said the grievances were reviewed during the morning stand up meetings with the interdisciplinary team.</p> <p>The SSD said if the resident had a problem, it needed to be fixed right away and the staff should help the resident resolve the concern. She said she was not aware of Resident #20's grievances of being left without incontinence care for long periods at a time or long call waits.</p> <p>The SSD said she would rewrite a resident's grievance if she felt it was not legible. She said she would not keep the resident's original grievance form, just the one she rewrote.</p> <p>(continued on next page)</p>		

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<p>F 0565</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Some</p>	<p>The DON was interviewed on 2/11/25 at 4:24 p.m. The DON said she just saw (on 2/11/25) Resident #20's 1/22/25 and 1/23/25 grievances regarding his concerns on long waits to receive care. She said she looked at call light logs every couple of weeks but did not look at his times. The DON said she did not know about Resident #20's concerns. She said if she was made aware of his grievances, he would have been more on her radar to identify why he was not getting or feeling that he was not getting timely care. She said she had noticed the long call light times of Resident #1. The DON said she has not done an investigation yet on why Resident #1's call light response times have been long. She said long times for the resident to have to wait could be attributed to staff not making routine rounds as they should or not anticipating the residents' needs. She said the staff received education on rounding in December 2024 (see education above). The DON said she would need to do more staff education to remind them that all residents needed timely care.</p> <p>The NHA was interviewed on 2/11/25 at 5:12 p.m. She said the call light average was six minutes in December 2024 and now the average time was five minutes so overall times are improving. She said she thought the resident council concern of long waits for help was resolved because it was not brought up in the last resident council.</p> <p>The NHA said she did not look at resident council minutes as thoroughly as she should. She said the facility did not have action plans/grievances related to resident council's concerns of long staff waits for help to identify a follow up to their concern.</p> <p>The NHA said moving forward she would start looking at individual call light times to watch for patterns and which staff were working at the time and try to find out why there were long light response times.</p> <p>XI. Facility follow-up</p> <p>The grievance process education was provided by the NHA on 2/11/25 at approximately 5:15 p.m. The education was provided to 28 staff members on 2/11/25 (during the survey process). According to the provided education, the staff were instructed to promptly bring any grievance forms they received from residents to the SSD, the DON or the NHA.</p>		