

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 07/01/2025
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 0580</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Immediately tell the resident, the resident's doctor, and a family member of situations (injury/decline/room, etc.) that affect the resident.</p> <p>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** III. Failed to ensure Resident #2's representative was notified when the resident was sent to a cardiology appointment and started on an anticoagulant medication</p> <p>A. Resident status</p> <p>Resident #2, age greater than 65, was admitted on [DATE]. According to the June 2025 CPO, diagnoses included type 2 diabetes mellitus without complications, other specified diabetes mellitus with diabetic neuropathy, presence of cardiac pacemaker, dementia, unspecified severity without behavioral disturbance, psychotic disturbance, mood disturbance and anxiety and unspecified atrial fibrillation.</p> <p>The 4/23/25 MDS assessment identified Resident #2 was cognitively intact with a brief interview for mental status (BIMS) score of 15 out of 15. Resident #2 used a walker for mobility and was independent with most of his activities of living (ADL).</p> <p>B. Resident interview</p> <p>Resident #2 was interviewed on 6/30/25 at 4:40 p.m. Resident #2 said he was placed on a blood thinner medication after he went to his cardiology appointment. He said he let his representative know of the medication changes. He said his representative did not know about the appointment and medication changes until he told her about them.</p> <p>C. Resident representative interview</p> <p>Resident #2's former representative was interviewed on 7/1/25 at 2:13 p.m. The former representative said while she was the resident's representative, she was not informed of medication changes and medical appointments by the facility. She said the facility started Resident #2 started on a blood thinner medication and he had a cardiology appointment. She said the facility never notified her about the cardiology appointments or the medication changes. She said she did not find out about the medication change and appointment until later in May 2025 when Resident #2 told her about them.</p> <p>D. Record review</p> <p>A 12/2/24 cardiologist encounter note identified Resident #2 had a cardiology appointment on 12/2/24.</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 0580</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>The 12/2/24 facility nursing note identified Resident #2 returned from the cardiology appointment.</p> <p>-Review of Resident #2's EMR did not reveal documentation to indicate that resident #2's representative had been notified of the 12/2/24 cardiology appointment.</p> <p>A 3/17/25 cardiologist encounter note identified Resident #2 had a cardiology appointment on 3/17/25. The encounter note indicated that Resident #2 would be started on Eliquis (anticoagulant/ blood thinner medication) 5 milligrams (mg) twice a day.</p> <p>The 3/17/25 order note identified Resident #2 returned to the facility from his cardiology appointment on 3/17/25 with a new medication order.</p> <p>Review of Resident #2's July 2025 CPO revealed a physician's order for Apixaban (Eliquis) 5 mg twice a day for unspecified atrial fibrillation, ordered 3/17/25.</p> <p>-Review of Resident #2's EMR did not reveal that Resident #2's representative was notified of the 3/17/25 appointment or the medication change.</p> <p>E. Staff education</p> <p>A 7/1/25 staff in-service training (conducted during the survey) with an attached staff participation log was provided by the NHA on 7/1/25 at 11:40 a.m. The education read,</p> <p>Long-term care, the standard of care for documenting conversations with residents and families involves timely, accurate, and objective charting that reflects relevance and supports quality of care, communication, and regulatory compliance.</p> <p>According to the training, documentation should occur immediately after a conversation was had with the resident's representative or before the end of the shift in which the event occurred.</p> <p>The staff participation log documented 15 staff members attended the 7/1/25 documentation training service.</p> <p>F. Staff interviews</p> <p>The NHA was interviewed on 7/1/25 at 2:29 p.m. The NHA said residents' representatives should be contacted when there was a change in condition, such as a medication change, or when a resident had a medical appointment scheduled. The NHA said Resident #2 had a cardiology appointment in December 2024 and again in March 2025. The NHA said Resident #2's EMR did not indicate Resident #2's representative was notified of the medication change or of his appointments.</p> <p>The NHA said the facility had multiple changes in managerial staff in recent months and there was no standardized process to notify residents' representatives and where to document the notifications. She said the facility nursing staff was educated today (7/1/25) regarding the documentation and notification process. The NHA said the director of nursing (DON) would provide oversight to ensure residents' representatives were appropriately notified and the staff documented the notification in the residents' EMRs.</p> <p>(continued on next page)</p>		

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<p>F 0580</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>The DON was interviewed on 7/1/25 at 5:16 p.m. The DON said she was new to the facility but she or a designated staff member would be responsible for notifying a resident's representative when there was a change of condition for the resident. The DON said the resident's representative would be called on the phone unless the representative identified another form of communication. She said if the representative was not available to take the call, she would leave a message and make sure to call them back again if they did not return the call. The DON said communication with residents' representatives and families was very important. The DON said good communication ensured residents' safety, an accurate care plan and made sure everyone was on the same page.</p> <p>Based on record review and interviews, the facility failed to make immediate notification to the resident representative when the resident had a significant change in condition requiring a need to alter treatment, initiate a resident's transfer or discharge from the facility or when the resident was involved in an accident with an injury for two (#8 and #2) of four residents out of eight sample residents.</p> <p>Specifically, the facility failed to:</p> <ul style="list-style-type: none"> -Ensure Resident #8's representative was notified when the resident reported pain to her right hip and had difficulty bearing weight on her right leg on 6/24/25 or when the resident was transferred later that same day from an outpatient physician's office visit to the hospital for Xrays of her right leg; and, -Ensure Resident #2's representative was notified when the resident was sent to a cardiology appointment and started on an anticoagulant medication (a blood thinning medication used to reduce the risk of heart attacks, strokes and blood clots). <p>Findings include:</p> <p>I. Facility policy and procedure</p> <p>The Change in Condition of Status policy, revised January 2021, was provided by the nursing home administrator (NHA) on 7/1/25 at 5:10 p.m. It read in pertinent part,</p> <p>Our facility promptly notifies the resident, his or her attending physician, and the resident representative of changes in the resident's medical/mental condition and/or status (changes in level of care, billing/payments, resident rights).</p> <p>A significant change of condition is a major decline or improvement in the resident's status that:</p> <ul style="list-style-type: none"> -will not normally resolve itself without intervention by staff or by implementing standard disease-related clinical interventions; -impacts more than one area of the resident's health status; -requires interdisciplinary review and/or revision to the care plan; and, -ultimately is based on the judgment of the clinical staff and the guidelines outlined in the resident assessment instrument. <p>(continued on next page)</p>		

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<p>F 0580</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>-However, there was no documentation in the resident's electronic medical record (EMR) to indicate the facility had followed up with the resident's representative to ensure he was aware that the resident had been transferred to the hospital from the physician's office.</p> <p>D. Staff interviews</p> <p>The NHA was interviewed on 7/1/25 at 4:30 p.m. The NHA said the facility was notified by the outpatient physician's office (on 6/24/25) that Resident #8 was being sent to the hospital for Xrays. She said the facility assisted with the resident's transport to the hospital. She said she did not have any documentation that indicated the facility notified Resident #8's representative to inform him that the resident was being admitted to the hospital. She said she recently recognized that the facility could improve the documentation regarding communication with residents' families/representatives.</p> <p>E. Facility follow-up</p> <p>On 7/2/25 at 11:46 a.m. the NHA sent an email communication which documented she had spoken with the nurse caring for Resident #8 on the evening of 6/24/25 and the unit nurse told her she had spoken to Resident #8's representative in the evening (on 6/24/25). The NHA documented in the email that the unit nurse told her she did not document notifying the resident's representative because she thought he already knew.</p> <p>The NHA provided an updated late entry progress note which documented the notification to the resident's representative on 6/24/25 at 8:01 p.m.</p> <p>-However, the resident's representative was not notified by the facility at the time the resident was initially sent to the hospital from the physician's office, at least four hours prior to the progress note documentation on 6/24/25.</p>		

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<p>F 0600</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Protect each resident from all types of abuse such as physical, mental, sexual abuse, physical punishment, and neglect by anybody.</p> <p>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observations, record review and interviews, the facility failed to ensure one (#4) of three residents reviewed for abuse out of eight sample residents were kept free from abuse.</p> <p>Specifically, the facility failed to protect Resident #4 from verbal abuse and physical abuse by Resident #5.</p> <p>Findings include:</p> <p>I. Facility policy and procedure</p> <p>The Abuse, Neglect, Exploitation or Misappropriation-Reporting and Investigating policy, revised September 2022, was provided by the nursing home administrator (NHA) on 7/2/25 at 11:10 p.m. via email. The policy read in pertinent part, All reports of resident abuse (including injuries of unknown origin), neglect, exploitation, or theft/misappropriation of resident property are reported to local, state and federal agencies (as required by current regulations) and thoroughly investigated by facility management. Findings of all investigations are documented</p> <p>and reported.</p> <p>Upon receiving any allegations of abuse, neglect, exploitation, misappropriation of resident property or injury of unknown source, the administrator is responsible for determining what actions (if any) are needed for the protection of residents.</p> <p>II. Facility investigations of incidents between Resident #4 and Resident #5</p> <p>A. Incident of verbal abuse of Resident #4 by Resident #5 on 5/27/25</p> <p>The facility investigation was provided by the NHA on 6/30/25 at 2:45 p.m. The investigation documented that on 5/27/25 Resident #5 verbally threatened Resident #4.</p> <p>According to the investigation, Resident #5 was interviewed on 5/28/25, a day after the incident occurred. The alleged assailant interview summary documented Resident #5 was very upset and did not want to see Resident #4 in her hall. The interview summary indicated Resident #5 was instructed to use her call light if she thought someone was going to enter her room. Resident #5 agreed to the use of the call light.</p> <p>The investigation identified Resident #4 was interviewed on 5/28/25, a day after the incident occurred. According to the alleged victim summary, Resident #4 was calm and did not remember the incident.</p> <p>(continued on next page)</p>		

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<p>F 0600</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>The investigation revealed Resident #5 saw Resident #4 in the hallway. Resident #5 made threatening statements towards Resident #4 while following her and told Resident #4 that she should not be in this hall or around Resident #5's room. The investigation documented the residents immediately were separated as Resident #5 continued to make threatening statements to staff that she would kill Resident #4 if she came into her room.</p> <p>Resident #5 was educated on the use of threatening and strong language towards other residents. According to the investigation, Resident #5 was reassured that staff was always available to make sure that Resident #4 did not enter Resident #5's room. The investigation documented the residents' rooms were on different sides of the facility and staff were instructed to re-direct residents who wandered down towards Resident #5's room.</p> <p>The facility substantiated the verbal abuse allegation based on interviews with staff and documentation.</p> <p>B. Incident of physical abuse of Resident #4 by Resident #5 on 5/29/25</p> <p>The facility investigation was provided by the NHA on 6/30/25 at 2:45 p.m. The investigation documented that on 5/29/25 a staff member witnessed Resident #5 grab and choke Resident #4. The residents were assessed and no injuries were noted.</p> <p>Resident #4 was interviewed on 5/29/25. She could not recall the incident.</p> <p>Resident #5 was interviewed on 5/29/25 after the incident. The alleged assailant interview summary documented Resident #5 said she saw Resident #4 coming down the hall and went after her because she did not want the resident to go into her room. The interview summary identified Resident #5 was worried that someone would enter her room. Resident #5 was offered a stop sign across her room door and reminded to use her call light.</p> <p>The facility substantiated that physical abuse occurred.</p> <p>III. Resident #4 (victim)</p> <p>A. Resident status</p> <p>Resident #4, age greater than 65, was admitted on [DATE]. According to the July 2025 computerized physician orders (CPO), diagnoses included dementia, severe with mood disturbance, Alzheimer's disease with late onset, cognitive communication deficit, need for assistance with personal care, weakness and difficulty in walking.</p> <p>The 6/10/25 minimum data set (MDS) assessment identified Resident #4 had severe cognitive impairments with a brief interview for mental status (BIMS) score of four out of 15. She required assistance with activities of daily living (ADLs) and used a wheelchair for mobility.</p> <p>The assessment indicated the resident had inattention, disoriented thinking and verbal behavioral symptoms directed towards others.</p> <p>The assessment indicated she did not have wandering behaviors.</p> <p>(continued on next page)</p>		

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<p>F 0600</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>B. Resident interview and observation</p> <p>On 7/1/25 at 4:35 p.m. Resident #4 was in her room sitting on her bed. The resident wore a wanderguard around her ankle. Resident #4 said everyone was nice to her and she felt safe.</p> <p>C. Record review</p> <p>The elopement care plan, revised 3/7/25, identified Resident #4 wandered related to Alzheimer's/dementia or other cognitive deficit behavior. According to the elopement care plan goal, Resident #4's safety would not be endangered related to her behaviors. Interventions, initiated 10/31/24, directed staff to monitor Resident #4's whereabouts frequently and monitor her environment for hazards which may increase need for supervision.</p> <p>The cognition care plan, initiated 11/8/24 and revised 6/25/25, identified Resident #4's severe cognitive deficit impaired her decision making skills. According to the care plan, Resident #4 would wander in the halls and into other residents ' rooms. Interventions included anticipating Resident #4's needs and promptly meeting those needs (initiated 11/8/24) and providing redirection when she wandered (initiated 6/2/25).</p> <p>-The comprehensive care plan did not identify Resident #4 was at risk for abuse due to her cognition and wandering into other residents ' rooms.</p> <p>Review of Resident #4's electronic medical record (EMR) revealed the following progress notes:</p> <p>The 3/28/25 nursing note identified Resident #4 was slapped by another resident (Resident #5).</p> <p>-However, according to the facility investigation, Resident #4 was the aggressor.</p> <p>The 5/28/25 weekly summary note documented Resident #4 had an incident that involved another resident (Resident #5) during the week. According to the note, staff would continue to monitor her.</p> <p>-There was no further documentation regarding the 5/27/25 verbal abuse incident with Resident #5 documented in Resident #4's EMR.</p> <p>The 6/4/25 weekly summary note documented there were no new skin concerns this week and Resident #4 had an altercation with another resident. According to the note, the nurse would continue to monitor.</p> <p>-There was no further documentation regarding the 5/29/25 physical abuse incident with Resident #5 documented in Resident #4's EMR.</p> <p>The 6/10/25 social services note document Resident #4 was pleasant and showed no signs of distress.</p> <p>IV. Resident #5 (assailant)</p> <p>A. Resident status</p> <p>(continued on next page)</p>		

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<p>F 0600</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Resident #5, age greater than 65, was admitted on [DATE]. According to the July 2025 computerized physician orders (CPO), diagnoses included multiple sclerosis, other symptoms and signs involving cognitive functions and awareness, anxiety disorder, depression, dementia in other diseases classified elsewhere, severe with mood disturbance.</p> <p>The 4/15/25 MDS assessment identified Resident #5 had severe cognitive impairments with a BIMS score of six out of 15. Resident #5 did not use a mobility device and was independent with most of her ADLs.</p> <p>She did not have inattention and disoriented thinking, but she had hallucinations and delusions.</p> <p>The assessment did not identify the resident had physical and verbal behavioral symptoms directed towards others.</p> <p>B. Resident interview and observation</p> <p>Resident #5 was interviewed on 7/1/25 at 4:48 p.m. Resident #5 said she was trying to get over being angry. She said there was a lady that lived at the facility that came into her room and destroyed all her photos of her family. She said she beat up the resident when she saw her. Resident #5 said she was going to go after her again when she saw the resident a couple days ago but God stopped her from doing anything. She said a couple staff members saw the resident near her room and ran down the hall to get the other resident away from her. Resident #5 said she was offered a stop sign but the stop sign did not work to keep the other resident out of her room. She said the other resident came into her room anyway.</p> <p>Resident #5 pointed at a balled up stop sign banner resting on top of a box next to the door. She said she just wanted the other resident to stay away from her. She said the other resident's room was on the other side of the facility. She said she had recently accepted the Lord and knew she could not do anything to the other resident.</p> <p>C. Record review</p> <p>The behavior care plan care plan, initiated 6/2/25 and revised 6/12/25, identified Resident #5 was at risk for psychosocial well-being concerns. According to the care plan, she believed that someone else was messing with her belongings in her room. Interventions included assisting Resident #5 with conflict resolution as needed, observing for tearfulness, increased agitation, and decreased participation in care (initiated 4/24/25) and providing her with a stop sign barrier for her room door to reduce anxiety associated with her beliefs that unwelcome people would enter her room (initiated 6/12/25).</p> <p>-The stop sign barrier was not initiated until two weeks after Resident #5 was involved in two abuse incidents with Resident #4 (see investigations above).</p> <p>(continued on next page)</p>		

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<p>F 0600</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>The psychosocial-mood care plan, initiated 6/2/25 and revised 6/12/25, identified Resident #5 was at risk for decreased psychosocial well-being and adjustment issues, emotional distress, ineffective coping skills, poor impulse control, adverse effects on function, mental, physical, social, or spiritual wellbeing related to depression and dementia with behaviors/hallucinations/delusions. According to the care plan, Resident #5 believed there was a tiny woman in her room and believed residents would come into her room, touch her belongings and possibly take them. The care plan identified Resident #5 would exhibit behaviors of agitation and verbal aggression. Interventions, initiated on 6/2/25, directed staff to administer medications as ordered and monitor for side effects as indicated, assess coping strategies and respect Resident #5's wishes to the extent possible, encouraging her to voice feelings and frustrations as indicated, and listening attentively, observing ineffective sleeping patterns, tearfulness, increased agitation, and decreased participation in care.</p> <p>The anxiety care plan, initiated 5/13/25, directed staff to monitor/record/document occurrences and targeted behavior symptoms of pacing, wandering, disrobing, inappropriate response to verbal communication, and violence/aggression towards staff/others.</p> <p>-The comprehensive care plan did not identify specific residents that Resident #5 should be kept apart from as identified in the 5/27/25 progress note (see below).</p> <p>-The comprehensive care plan did not identify Resident #5 was at risk for abuse or of abusing others.</p> <p>Review of Resident #5's July 2025 CPO revealed a physician's order to document Resident #5's targeted behaviors of combativeness, harm to self or others, delusions, hallucinations or other behaviors, ordered 5/23/25.</p> <p>The May 2025 medication administration record (MAR) identified Resident #5 had behaviors on 5/25/25 (hallucinations), however, the MAR documented the resident did not have any behaviors on 5/27/25 or 5/29/25, marking No for behaviors.</p> <p>-However, Resident #5 was the assailant in a verbal incident with Resident #4 on 5/27/25 and a physical incident with Resident #4 on 5/29/25 (see investigations above).</p> <p>Review of Resident #5's EMR revealed the following progress notes:</p> <p>The 3/16/25 behavior note identified Resident #4 would not leave Resident #5's room so Resident #5 attempted to physically move Resident #4 out of room. Resident #5 reported to staff that Resident #4 would frequently try to go into her room so she would put a trash can in front of her to try to keep Resident #4 out of her room.</p> <p>The 3/28/25 nursing note documented Resident #5 suffered physical abuse from another resident (Resident #4). Resident #5 said she was attacked in her bedroom. According to the note, Resident #5 had a bruise to her right arm from defending herself.</p> <p>The 3/29/25 summary for providers note identified Resident #5 was moved to another room in another unit after the incident because Resident #4 and Resident #5 shared a bathroom. According to the note, the physical altercation incident should not happen again.</p> <p>(continued on next page)</p>		

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<p>F 0600</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>The 5/27/25 summary for providers note identified Resident #5 had behavioral symptoms of new or worsened delusions or hallucinations and verbal aggression. According to the note, the recommendations were to keep them apart. The note did not identify who to keep apart or details of the 5/27/25 verbal aggression incident.</p> <p>-There was no further documentation regarding the 5/27/25 verbal abuse incident with Resident #4 documented in Resident #5's EMR.</p> <p>The 5/29/25 nursing progress note documented Resident #5 was involved in a resident to resident altercation. The progress note identified the residents were separated and skin assessments were completed. According to the progress note, there were no injuries and Resident #5 was educated to notify staff prior to physical contact with another resident.</p> <p>The 6/2/25 interdisciplinary (IDT) note documented staff met with Resident #5 to provide active listening and determine the root cause of her increased anxiety and fear of others entering her room. The note indicated Resident #5 was provided education regarding language utilized in hallways and around/towards other residents or staff. According to the note, the resident's feelings were validated and offered alternative options when she had increased anxiety regarding other residents, such as staff notification and allowing staff to intervene. The resident was provided with relaxing and coping strategies.</p> <p>The 6/7/25 weekly summary note documented Resident #5's hallucinations were improving. According to the note, there were decreased reports of her seeing other people in the room. However, the note indicated she continued to talk about another resident coming to her room. The note identified Resident #5 started to barricade her room door with a walker. The resident was told that staff would check on her at times and there was no need to barricade the door.</p> <p>The 6/12/25 IDT note documented Resident #5's room had a stop sign barrier in place as needed to reduce her anxiety surrounding the belief that someone may enter her room unwelcomed. According to the note, the resident's Risperdal (anti-psychotic medication) was increased on 6/9/25 due to hallucinations and delusions that resulted in her restless agitation which sometimes escalated to verbal and physical altercations.</p> <p>V. Staff education</p> <p>An undated staff education posting was provided by the NHA on 7/1/25 at 6:56 p.m. The posting documented the purpose of the education was to educate floor staff on effective, person-centered redirection techniques for residents exhibiting confusion, exit-seeking, agitation, or repetitive behaviors related to dementia or cognitive impairment. The education outlined the key points of person-centered redirection techniques, to include understanding the purpose of redirection; recognizing when redirection was needed; techniques; examples and team approaches.</p> <p>According to the education, staff should utilize resident behavior tracking to identify patterns or triggers and communicate redirection strategies during change of shift reports. The posting indicated consistency between the shifts (on the strategies) were essential (see interview below).</p> <p>VI. Staff interviews</p> <p>(continued on next page)</p>		

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<p>F 0600</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>The NHA was interviewed on 6/30/25 at 4:32 p.m. The NHA identified herself as the facility's abuse coordinator. She said after an abuse incident or allegation, statements would be gathered, skin assessments would be completed, video cameras would be checked and the appropriate parties would be notified. She said she would try to determine what happened and report the incident to the State Agency.</p> <p>Registered nurse (RN) #1 was interviewed on 7/1/25 at 5:07 p.m. RN #1 identified herself as Resident #5's nurse but she said she had only worked with the resident four times. She said she was told Resident #5 had moved to her current room because there was a problem with another resident. She said she had not had any problems with Resident #5. RN #1 said Resident #5 had been polite to her and she had not seen any signs of aggression towards others. She said Resident #5 spent most of her time in her room. She said she was not told there were certain residents that Resident #5 should avoid having contact with or that she should not be near other than residents who wandered. She said she had not seen wandering residents near Resident #5 or her room. RN #1 said she was not told that Resident #5 needed extra supervision or monitoring. She said the resident spent most of her time in her room.</p> <p>The director of nursing (DON) was interviewed on 7/1/25 at 5:16 p.m. The DON said all reports of abuse went to the NHA. She said the facility was in the process of educating staff that if a resident used words identifying they were fearful or words that were threatening, it could be an indication of abuse and needed to be reported. The DON said she was aware of the altercations between Resident #4 and Resident #5. She said the staff were directed to use frequent purposeful rounding to prevent future altercations between the residents. She said the rounding was not documented. She said staff had been notified that there was a resident (Resident #4) that would wander from the East hall to the [NAME] hall were Resident #5 resided. The DON said staff should watch the whereabouts of both residents. She said the residents should be care planned for their risk of abuse.</p> <p>Certified nurse aide (CNA) #2 was interviewed on 7/1/25 at 5:32 p.m. CNA #2 was identified as a CNA for the East hall. CNA #2 said to prevent resident-to-resident altercations, she would redirect the residents and try to find out what the residents needed or offer a distraction. CNA #2 said she was not aware of any residents who had specific interventions to prevent altercations or what frequent purposeful rounding was.</p> <p>CNA #1 was interviewed on 7/1/25 at 5:39 p.m. CNA #1 was identified as a [NAME] side CNA. She said to help prevent resident to resident altercations, she would try to walk with the resident, get them a drink or snack. She said if the resident recognized a certain person as the source of agitation, she would separate the residents from each other. She said she knew staff had separated Resident #4 and Resident #5 from each other because the residents were supposed to remain as separated as possible. She said if the one resident from the East hall wandered down the other hall, staff would distract and redirect her back to her hall. She said she thought the frequent purposeful rounding was brought up at a staff or nurses meeting, but she was not able to stay in the meeting long enough to hear everything about it.</p> <p>(continued on next page)</p>		

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<p>F 0600</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>The NHA was interviewed on 7/1/25 at 6:13 p.m. The NHA said Resident #4 and Resident #5 had a history of behaviors with each other. She said Resident #4 and Resident #5 used to share an adjoining bathroom. She said Resident #4 would get confused and would exit out the wrong bathroom door and into Resident #5's room. The NHA said staff put up a stop sign by Resident #5's bathroom door but it would continue to happen. She said staff moved Resident #5 out of the room with the shared bathroom and across the hall, but on 3/28/25, Resident #4 went into Resident #5's room again causing a resident to resident altercation. She said Resident #5 agreed to move to a room on the opposite side of the facility. The NHA said Resident #5 started to perseverate on her photos looking different in April 2025 but nothing changed with the photos and no one was doing anything to them. The NHA said Resident #5 was having delusions and a medication change was made.</p> <p>The NHA said on 5/27/25 the residents started to argue in the common area and Resident #5 threatened to harm Resident #4. The NHA said on 5/29/25, staff reported they witnessed Resident #5 was trying to strangle Resident #4. She said she looked at the video footage but could only identify Resident #4's shirt was grabbed by Resident #5. She said neither resident had injuries as a result of the altercations. The NHA said a stop sign at the door was offered to Resident #5 after the physical altercation but the resident did not use it. The NHA said Resident #5 said she did not need it because God told her not to hurt anyone.</p> <p>The NHA was interviewed again on 7/1/25 at 6:27 p.m. The NHA said she provided staff with a verbal education and posted a sign at the East nurses ' station for staff to read after the 5/29/25 resident to resident altercation between Resident #4 and Resident #5. The NHA said she could not find the education posting at the East nurses ' station but would continue to look for it or provide a copy (see above). The NHA said the facility needed to do a better job of documenting interventions and education. She said there was only a short period of time between the verbal abuse incident and the physical abuse incident between Resident #5 and Resident #4 in May 2025. She said staff should have been educated as soon and preferably right after the 5/27/25 incident or first thing the next morning, to help prevent future incidents. The NHA said there should have been more documented, other than a nurse's note that identified the residents should be kept separated after the 5/27/25 incident. She said there might have been another piece of documentation to keep an eye on the residents but she was not sure.</p>		

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<p>F 0627</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Ensure the transfer/discharge meets the resident's needs/preferences and that the resident is prepared for a safe transfer/discharge.</p> <p>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on record review and interviews, the facility failed to ensure one (#1) of three residents were provided the care and services necessary to ensure a safe discharge from the facility to the community out of eight sample residents.</p> <p>Specifically, the facility failed to:</p> <ul style="list-style-type: none"> -Allow Resident #1 to return to the facility after an unplanned discharge to the hospital; -Provide documentation made by Resident #1 ' s physician, including the specific resident needs the facility could not meet, the facility ' s efforts to meet those needs and the specific services the receiving facility would provide to meet the needs of the resident which could not be met at the current facility; and, -Reassess Resident #1 for readmission after he was stabilized at the hospital and ready to return to the facility. <p>Findings include:</p> <p>I. Facility policy and procedure</p> <p>The Transfer or Discharge policy, revised March 2025, was provided by the nursing home administrator (NHA) on 7/1/25 at 5:10 p.m. The policy read in pertinent part,</p> <p>If the basis for the transfer or discharge is that the transfer or discharge is necessary for the resident ' s welfare, and the resident ' s needs can not be met in the facility, the resident ' s physician (or provider) documents: the specific resident needs that can not be met; the facility ' s attempt to meet those needs; and, the receiving facility ' s service(s) that are available to meet those needs.</p> <p>In situations where the facility determines the resident ' s clinical or behavioral status endangers the safety or health of individuals in the facility, the documentation regarding the reason for the transfer or discharge is provided by a physician or provider (but not necessarily the resident ' s physician or provider).</p> <p>Upon notice of transfer or discharge, the resident is provided with a statement of his or her right to appeal the transfer or discharge, including: the name, address, email, and telephone number of the entity which receives such requests; information about how to obtain, complete, and submit an appeal form; how to get assistance completing the appeal process; and, the facility bed-hold policy.</p> <p>II. Resident #1</p> <p>A. Resident status</p> <p>(continued on next page)</p>		

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<p>F 0627</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Resident #1, age less than 65, was admitted on [DATE] and discharged to the hospital on 6/9/25. According to the June 2025 computerized physician orders (CPO), diagnoses included depression, developmental delay in childhood, suicide attempt, skin graft failure, muscle contractures and larynx stenosis (a condition requiring a permanent tracheostomy).</p> <p>The 3/19/25 minimum data set (MDS) assessment revealed the resident had moderate cognitive impairment with a brief interview for mental status (BIMS) score of 12 out of 15. The resident required assistance with eating, bathing and hygiene.</p> <p>The MDS assessment indicated the resident had behavioral symptoms directed at others, including yelling, threatening, cursing and throwing items.</p> <p>B. Resident #1 ' s representative interview</p> <p>Resident #1 ' s representative was interviewed on 6/30/25 at 11:23 a.m. The representative said another representative received a call from the facility in the evening on 6/9/25 to inform them Resident #1 was transferred to the hospital due to his behaviors. The representative said the hospital told her Resident #1 appeared stable in the emergency room and did not meet inpatient criteria. She said the hospital was willing to provide a courtesy admission because Resident #1 required assistance to maintain his tracheostomy.</p> <p>She said she spoke with the NHA the next day (6/10/25) and the NHA told her Resident #1 was not allowed to return to the facility, because they could no longer meet his needs and his behaviors were a danger to himself and others. She said the facility reiterated to her that Resident #1 was not allowed to return to the facility on 6/12/25 and she was served a notice of discharge on [DATE], 11 days after the transfer occurred.</p> <p>The representative said the hospital told her Resident #1 had mildly disruptive behavior but had been redirectable by staff. She said the facility and the hospital had spoken to her about finding a new facility for Resident #1, but he had not been accepted anywhere and remained at the hospital at the time of the interview. The representative said Resident #1 wanted to return to the facility and the representative said she was not aware Resident #1 was allowed to appeal the discharge or who to contact for assistance with filing the appeal.</p> <p>C. Record review</p> <p>The progress note, dated 6/9/25, documented Resident #1 had escalating behaviors throughout the shift including yelling and cursing at staff, threatening to kill everybody, repeatedly slamming his door and attempting to take apart his tracheostomy device. The charge nurse, the NHA and emergency medical services (EMS) were called. Resident #1 was placed on five-minute checks. The note documented that when EMS arrived to the facility, Resident #1 told EMS he wanted to harm the facility staff and he was assisted to the local area hospital by EMS.</p> <p>The notice of discharge, dated 6/20/25, was provided by the NHA on 7/1/25 at 3:35 p.m. It documented the reason for discharge was Resident #1 ' s welfare could not be met in the facility and the safety or health of individuals in the facility was endangered. It documented the needs that could not be met were Resident #1 ' s multiple attempts to harm himself during his stay and he threatened to harm staff.</p> <p>(continued on next page)</p>		

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<p>F 0627</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>-However, review of Resident #1 ' s electronic medical record (EMR) did not reveal documentation that a physician agreed to the resident ' s discharge.</p> <p>-The section of the form for the physician ' s signature was blank and there was no physician's order for discharge.</p> <p>-The section of the form that indicated the contact information for the ombudsman's office for assistance if the resident wished to appeal the discharge was blank.</p> <p>-Additionally, the facility documented an address to another facility for Resident #1 to discharge to, however the facility listed on the form denied the resident ' s admission.</p> <p>-Review of Resident #1 ' s EMR did not reveal documentation that the facility reassessed Resident #1 after he was stabilized in the hospital and ready to return to the facility in order to determine if the facility could meet the residents needs.</p> <p>III. Interviews</p> <p>A frequent visitor was interviewed on 6/30/25 at 11:23 a.m. The frequent visitor said the local hospital called her on 6/17/25 and informed her the facility refused to readmit Resident #1. She said she contacted the facility on 6/18/25 because she had not received a notice of discharge for the resident. She said the facility told her the NHA decided Resident #1 was not allowed to come back to the facility. She said she received a notice of discharge from the facility on 6/20/25, but she told the NHA the form was missing the contact information for the local frequent visitor required on discharge and she told the NHA she needed a corrected form. She said she had not received a corrected form at the time of the interview.</p> <p>The hospital case manager was interviewed on 7/1/25 at 12:14 p.m. The hospital case manager said Resident #1 arrived at the hospital with the initial complaint of becoming aggressive with staff after an argument over the resident having a can of soda. She said according to observations from hospital staff, Resident #1 had been redirectable with boundaries and reminders from unit staff. She said at no time since his admission to the hospital had Resident #1 required one-to-one supervision or the use of as needed medication to manage his behaviors. She said he told staff he had friends at the facility and would like to return home. The hospital case manager said she contacted her supervisor when the facility told her Resident #1 was not allowed to return to the facility. She said the regional operations manager from the facility told her Resident #1 had an accepted referral to a sister facility. She said when she contacted the sister facility, she was told the facility had not received referral information for Resident #1.</p> <p>The supervisor of case management for the hospital was interviewed on 7/1/25 at 12:38 p.m. supervisor of case management said she spoke with the regional operations manager for the facility on 6/20/25. She said the regional operations manager told her he reached out to other facilities in their network. She said she heard back from the regional operations manager later and only one facility considered admitting Resident #1, but declined due to his tracheostomy. She said she had not heard anything new from the facility since those referrals fell through.</p> <p>(continued on next page)</p>		

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<p>F 0627</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>The facility ' s admissions assistant was interviewed on 6/30/25 at 1:52 p.m. The admissions assistant said she usually managed the discharge process for residents at the facility. She said normally if a resident needed to be sent to a hospital, it was a transfer and completed by nursing staff because the expectation was for the resident to return to the facility. She said when she found out Resident #1 was transferred to the hospital and discharged from the facility without notice, she told the NHA she was not comfortable completing the discharge. She said to her knowledge, the NHA completed the discharge process for Resident #1.</p> <p>The NHA was interviewed on 6/30/25 at 3:12 p.m. The NHA said she was called about Resident #1 ' s behavior on 6/9/25 and directed the nursing staff to contact EMS. She said a few days later, the hospital was requesting to send Resident #1 back to the facility. She said she spoke with her regional operations manager and they agreed that Resident #1 was not allowed to return to the facility because the facility could not meet his needs and because Resident #1 was a danger to himself and other residents. She said when the interdisciplinary team (IDT) reviewed his case, the facility did not follow all of the regulations for Resident #1 ' s discharge, but felt the danger Resident #1 posed to other residents and staff outweighed the risk. She said she and the regional operations manager contacted other facilities in their network but the only potential facility fell through. The NHA said the last time she spoke with the case manager from the local hospital was approximately 6/23/25 when the potential facility fell through. She said to her knowledge, Resident #1 remained at the hospital as of the time of the interview.</p>		

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<p>F 0742</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Provide the appropriate treatment and services to a resident who displays or is diagnosed with mental disorder or psychosocial adjustment difficulty, or who has a history of trauma and/or post-traumatic stress disorder.</p> <p>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on record review and interviews, the facility failed to ensure that residents requiring treatments and services for mental disorders or psychosocial adjustment difficulties received appropriate treatment and services to correct the assessed problem or to attain the highest practicable mental and psychosocial well being for one (#1) of three residents reviewed out of eight sample residents.</p> <p>Specifically, the facility failed to provide mental health counseling services for Resident #1.</p> <p>Findings include:</p> <p>I. Facility policy and procedure</p> <p>The Behavioral Health Services policy, revised February 2019, was received from the nursing home administrator (NHA) on 7/1/25 at 5:53 p.m. The policy read in pertinent part,</p> <p>Behavioral health services are provided to residents as needed as part of the interdisciplinary, person-centered approach to care.</p> <p>Residents who exhibit signs of emotional/psychosocial distress receive services and support that address their individual needs and goals for care.</p> <p>II. Resident #1</p> <p>A. Resident status</p> <p>Resident #1, age less than 65, was admitted on [DATE] and discharged to the hospital on 6/9/25. According to the June 2025 computerized physician orders (CPO), diagnoses included depression, developmental delay in childhood, suicide attempt, skin graft failure, muscle contractures and larynx stenosis (a condition requiring a permanent tracheostomy).</p> <p>The 3/19/25 minimum data set (MDS) assessment revealed the resident had moderate cognitive impairment with a brief interview for mental status (BIMS) score of 12 out of 15. The resident had behavioral symptoms directed at others including yelling, threatening, cursing and throwing items. The resident required assistance with eating, bathing and hygiene.</p> <p>B. Record review</p> <p>Review of the behavior care plan, revised 5/20/25, revealed Resident #1 exhibited symptoms of striking out, grabbing others, verbally or physically abusive, rearranging his room and furniture and inappropriate sexual behavior. Interventions included administering antipsychotic medications, behavior monitoring by staff for changes in behavior, documentation of changes in behavior including frequency and potential triggers and providing a psychiatrist consultation as indicated.</p> <p>(continued on next page)</p>		

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<p>F 0742</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>The Preadmission Screening and Resident Review (PASRR) Level II notice of determination for mental illness, dated 3/4/24, revealed specialized services were required for Resident #1. Services required included psychiatric case consultation, individual therapy and a neuropsychological assessment to understand his capacity and the assistance he required.</p> <p>The progress note, dated 4/27/25 at 10:53 p.m., revealed Resident #1 slammed his bedroom door and cursed at staff when staff attempted to redirect Resident #1 from giving soda to another resident who was diabetic.</p> <p>The progress note, dated 5/1/25 at 1:37 p.m., revealed Resident #1 yelled at staff when Resident #1 was asked by staff to leave another resident's room while the resident was not in the facility.</p> <p>The progress note, dated 5/2/25 at 8:25 a.m., revealed Resident #1 cursing at the respiratory therapist after the respiratory therapist noted the room was rearranged and asked the resident where he placed the suction machine.</p> <p>The progress note, dated 5/5/25 at 10:42 p.m., documented Resident #1 had sexually inappropriate behavior toward staff</p> <p>The progress note, dated 5/7/25 at 10:26 a.m., documented Resident #1 cursing at staff.</p> <p>-Review of Resident #1's electronic medical record (EMR) did not reveal documentation that indicated the facility set-up psychiatric case consultation or individual therapy despite the resident having increased behaviors.</p> <p>III. Staff interviews</p> <p>The nurse manager (NM) was interviewed on 6/30/25 at 2:54 p.m. The NM said he was the nurse on the unit the day Resident #1 was transferred to the local area hospital and the nurse who called emergency medical services (EMS). He said Resident #1 attempted to take apart and remove his tracheostomy multiple times on 6/9/25. The NM said Resident #1 had previous outbursts, but normally if the resident was asked to stop and given space he would calm down. The NM said on 6/9/25 Resident #1 was unable to be redirected and his behavior endangered himself and other residents.</p> <p>The NM said he did not know if Resident #1 received any individual therapy services, but the team was attempting to adjust his medications and the activities staff were trying to help with the resident's behavior with non-pharmacological interventions like music.</p> <p>The NHA was interviewed on 6/30/25 at 3:12 p.m. The NHA said in March 2025 Resident #1 left for the week to visit family. She said she was contacted and informed the police were called out to the home during the family visit due to a family altercation. She said Resident #1 had increased behavioral symptoms after this visit. She said when reviewing the weeks of documentation prior to Resident #1's discharge, she noted other times Resident #1 attempted to take apart his tracheostomy and that the facility could no longer keep the resident safe.</p> <p>Cross reference F627: failure to complete an appropriate discharge.</p> <p>(continued on next page)</p>		

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 07/01/2025
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 0742</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>The social services director (SSD) was interviewed on 6/30/25 at 3:48 p.m. She said she spoke with Resident #1 frequently, often checking in with him daily. She said when Resident #1 returned to the facility in March 2025 he told her his visit with family was not good and he could not go back. She said initially Resident #1 did not have increased behavior the week after the visit, so she thought he was okay. The SSD said Resident #1 did not receive any individual therapy services because the facility did not have a contract with a third party to provide individual therapy sessions until recently. She said it had been a long time since the previous company stopped providing services. She said to her knowledge, Resident #1 had not received individual therapy services since he was admitted to the facility on 10/19/24 to present.</p> <p>The NHA was interviewed again on 7/1/25 at 6:12 p.m. The NHA said the facility signed a contract with a new mental health provider on 5/27/25. She said she was not sure when the previous contract ended, but it had been a long time. The NHA said the facility used to have a provider that met with the residents in person, but they started showing up less frequently until they no longer came to the facility at all. The NHA said the facility then contacted a telehealth company for remote mental health services but the residents did not like the remote sessions. She said she did not know if any individual mental health services were provided to Resident #1 this spring while his behaviors escalated.</p>		