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	12/09/2025

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 0806 Level of Harm - Actual harm Residents Affected - Few	Ensure each resident receives and the facility provides food that accommodates resident allergies, intolerances, and preferences, as well as appealing options. (continued on next page)

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

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

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0806 Level of Harm - Actual harm Residents Affected - Few	**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on interviews and record review, the facility failed to serve food that accommodates resident allergies, intolerances, and preferences for one (#1) of five residents reviewed out of five sample residents.Specifically, the facility failed to ensure Resident #1 was not served food the resident was allergic to, causing an allergic reaction to Resident #1 which required hospitalization for anaphylactic shock (a severe, potentially life-threatening allergic reaction that can cause a range of symptoms affecting multiple body systems, including skin, respiratory, and cardiovascular).Resident #1 was admitted on [DATE] for long term care with diagnoses of unspecified lack of expected physiological development in childhood, cognitive communication deficit, muscle weakness, lack of coordination and history of anaphylaxis (severe allergic reaction). On 9/24/25 Resident #1 was served tilapia for lunch. Shortly after consuming the fish, Resident #1 developed itching and was having difficulties breathing. Resident #1 was transported to the hospital and was admitted to the intensive care unit (ICU) and treated for anaphylactic shock. Findings include:Record review, observations and interviews confirmed the facility corrected the deficient practice related to Resident #1 being served food with a known allergen prior to the onsite investigation on 10/9/25 to 10/13/25. The deficiency was cited as past non-compliance with a correction date of 10/5/25.I. Incident on 9/24/25The nursing home administrator (NHA) provided the facility investigation on 10/9/25 at 1:10 p.m. It revealed in pertinent part,The investigation summary documented that on 9/24/25 at approximately 12:30 p.m. Resident #1 was served a meal containing fish. The facility monitored the resident's vital signs and provided supplemental oxygen. The facility contacted emergency medical services (EMS) and the resident required hospitalization. [NAME] (CK) #1 was interviewed and admitted they did not check the diet ticket prior to sending the meal. Certified nurse aide (CNA) #1 was interviewed and admitted she did not check the diet order ticket prior to serving the resident. The investigation documented the staff members were suspended at the start of the investigation and then terminated.The investigation revealed CK #1 received a written warning and corrective education on 9/12/25 after serving a different resident a dessert with a known allergen. The investigation documented the facility completed immediate education of current staff within hours of the event. The investigation documented the facility completed an audit of all residents' allergies. In addition, the facility created new signage and education for floor staff to prevent recurrence.II. Facility plan of correctionA. Immediate action to correct the deficient practice for Resident #1The progress note, dated 9/24/25 at 9:25 p.m., revealed the interdisciplinary team (IDT) held an emergency meeting to review Resident #1's change in condition. The progress note revealed education was provided to the nursing and dietary staff on 9/24/25.The facility provided documentation of staff education completed after the incident which included the following:A document titled Food Allergies: Check the ticket inservice, documented an in-person education was provided by the NHA on 9/24/25. The document included five dietary aides, two cooks, 13 CNAs, one licensed practical nurse (LPN) and four registered nurse (RN) signatures. The documentation included education of a five point ticket check for staff to perform prior to serving any food. These five checks included: the resident name and second identification (picture or room number), diet order, texture, liquids and allergies/special notes. The documentation included education that if the tray did not match all five checks, staff were required to perform a stop protocol. The stop protocol directed staff to S-seperate the tray, T-tell nursing and dietary staff immediately, O-observe and ensure the resident did not eat anything from the incorrect tray, P-proof: document the near miss per facility policy.A document titled Food Allergens inservice, documented an in-person education was provided by the NHA on 9/24/25. The document included five dietary aides, two cooks, 13 CNAs, four RNs signatures and one LPN signature. The document included education on major food allergens, how allergens were listed on product labels, signs of an allergic reaction and how to respond at the onset of food allergy symptoms. A document titled ASAP (as soon as possible) dietary meeting inservice, documented an in-person education was provided by the director of nursing (DON) on 9/26/25. The document included five dietary aides, two cooks and one RN signature. The document included education of CMS (Centers for Medicare and Medicaid) standards for dietary standards in long term care and food handling safety including education of cross contamination.B. Identification of other residentsStarting on 9/29/25 through 10/1/25, the facility completed an audit of all residents' food allergies, preferences, and intolerances. One additional resident was identified with a previously undocumented allergy to fish and shellfish. The resident reported the allergy to the facility on