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	02/04/2026

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 0760 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	Ensure that residents are free from significant medication errors. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, record review and interviews, the facility failed to ensure one resident (#3) of three sample residents, was free from significant medication errors out of 13 sample residents.Resident #3 was admitted to the facility on [DATE] with a diagnosis of type 1 diabetes mellitus with a history of experiencing low blood glucose levels. Resident #3 had a physician's order to receive 29 units of Lantus (insulin glargine - long acting insulin) injected subcutaneously each day at bedtime. The resident had another physician's order for Humalog insulin (lispro - short acting insulin) 100 units per milliliters (ml) injected daily at 6:00 a.m., 11:00 a.m. and 4:00 p.m. On 10/22/25 at 7:33 p.m. registered nurse (RN) #1 administered 29 units of Humalog (quick acting insulin) instead of the scheduled Lantus (long acting insulin), which caused the resident's blood glucose to drop. When RN #1 realized the error, he administered the correct insulin in addition to the insulin he administered in error and then instructed the resident to monitor her own blood glucose levels and let him know the results. RN #1 failed to assess the resident's immediate and changing vital signs, so it was unknown how quickly the resident's blood glucose levels dropped and for how long the resident's blood glucose level remained at a dangerous life threatening level. Additionally, RN #1 waited approximately four and a half hours before sending the resident to the emergency room despite the director of nursing (DON) instructing him to send the resident to the hospital at that time per facility protocol. As a result of the facility's failure to ensure Resident #3 received the correct type and amount of diabetic medication at the right time Resident #3 experienced a life threatening hypoglycemic state where her blood glucose dropped to 42 milligrams per deciliter (mg/dL) for an undetermined amount of time. Emergency medical services (EMS) had to administer life saving oral glucose to the resident and take her to the hospital for close monitoring. Specifically, the facility failed to ensure Resident #3 was administered her insulin per physician's orders. Findings include:Record review and interviews confirmed the facility corrected the deficient practice prior to the onsite investigation on 2/2/26 to 2/4/26, resulting in the deficiency being cited as past noncompliance with a correction date of 10/24/25.I. Situation of serious harmThe facility failed to ensure Resident #3 received the correct type and amount of insulin, resulting in the administration of an excessive amount of insulin. The facility failed to directly monitor the resident's condition, including blood glucose measurements, heart rate and blood pressure following the significant medication error that was likely to cause the resident significant bodily harm. In addition, the facility failed to seek timely emergency medical service to ensure the resident's health and safety. II. Facility's plan of correction The corrective action plan implemented by the facility in response to Resident #3's serious medication error on 10/22/25 was provided by the nursing home administrator (NHA) on 2/3/26. The facility's plan of correction revealed the following: Identification of others - The facility took the following actions to prevent an adverse outcome from reoccurring. All applicable facility policies and procedures were reviewed and revised by the DON and the (continued on next page)

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

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

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 065286	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 02/04/2026
NAME OF PROVIDER OR SUPPLIER Eagle Ridge Post Acute		STREET ADDRESS, CITY, STATE, ZIP CODE 2425 Teller Ave Grand Junction, CO 81501	

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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 0760 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	medical director (MD) The facility reviewed all residents on diabetic medications to ensure correct orders and accurate care plans (completion date 10/24/25).Systemic changes - the DON or designee re-educated licensed nurses on facility policies and procedures regarding diabetic management and administration of diabetic medications. All nurses were educated prior to working their next shift. A complete medication review was conducted and all residents on insulin were prescribed glucagon for response to hypoglycemic events (completion date 10/24/25).Monitoring - the DON or designee will complete weekly chart audits on all residents receiving insulin medication to ensure accurate administration and no residents were experiencing an untreated hypoglycemic condition. This was to occur for three consecutive months.The administrator implemented a QAPI/PIP (quality assurance and performance improvement/performance improvement project) as a means to gather and process information from the audits. Findings will be reported at the monthly quality assurance meeting until satisfactorily resolved. III. Professional reference According to the American Diabetes Association (ADA), December 2025, retrieved on 2/17/26 from https://diabetes.org/living-with-diabetes/hyoglycemia-low-blood-glucose/severe Severe hypoglycemia occurs when a person's blood sugar drops dangerously low. The person may become confused, pass out (lose consciousness), or treatments for low blood glucose are not working. People who are at risk for severe hypoglycemia: people on blood glucose-reducing medications (insulin, sulfonylureas, or meglitinides), people with a history of severe hypoglycemia.Signs and symptoms of severe hypoglycemia include: An altered mental state; fainting or losing consciousness; incredibly weak and unable to help yourself; seizure; and coma. If left untreated for too long, severe hypoglycemia can lead to brain or organ damage or even death.IV. Facility policy and procedure The Administering Medications policy and procedure, revised 2020, was provided by the NHA on 2/3/26 1:28 p.m. It read in pertinent part,: Medications are administered in a safe and timely manner, and as prescribed. Medications are administered in accordance with prescriber orders, including any required time frame. The individual administering the medication initials the resident's medication administration record (MAR) on the appropriate line after giving each medication and before administering the next ones. As required or indicated for a medication, the individual administering the medication records in the resident's medical record:a. the date and time the medication was administered;b. the dosage;c. the route of administration;d. the injection site (if applicable);e. any complaints or symptoms for which the drug was administered;f. any results achieved and when those results were observed; andg. the signature and title of the person administering the drug.The Management of Hypoglycemia policy, revised 2020, was provided by the NHA on 2/3/26 at 1:28 p.m. It read in pertinent part, Purpose: to provide guidelines for managing hypoglycemia secondary to insulin therapy or therapy with oral hypoglycemic agents in the diabetic resident. Classification of hypoglycemia: Level 1 hypoglycemia: blood glucose less than 70 milligrams (mg) per deciliter (dL) but less than 54 mg/dL; Level 2 hypoglycemia: blood glucose is less than54 mg/dL; and Level 3 hypoglycemia: altered mental and/or physical status requiring assistance for treatment of hypoglycemia. For Level 2 hypoglycemia (less than54 mg/dL): a. Administer glucagon (intranasal, intramuscular, or as provided); b. Notify the provider immediately; c. Remain with the resident; d. Place resident in a comfortable and safe place (bed or chair); e. Monitor vital signs; andf. Recheck blood glucose in 15 minutes.V. Resident #3A. Resident statusResident #3, age less than 65, was admitted on [DATE], discharged to the hospital on [DATE], readmitted to the facility on [DATE] and discharged to the community on 1/7/26.According to the January 2026 computerized physician's orders (CPO), diagnosis included diabetes mellitus and traumatic brain injury. The 12/17/25 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.B. Resident (continued on next page)

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F 0760 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	interviewResident #3 was interviewed on 2/3/26 at 2:30 p.m. via the telephone. Resident #3 said RN #1 administered her insulin injection, pain and sleeping medication and left her room She said RN #1 returned later and told her he had made an error and gave her the incorrect insulin medication. Resident #3 said after telling her about the medication error RN #1 gave her a blood glucose monitor and the supplies to monitor her own blood glucose every 20 minutes. Resident #3 said RN #1 waited to call EMS until he heard back from the on-call doctor when he should have called EMS right away. C. Facility investigation The facility investigation documented on 10/23/25 RN #1 administered the wrong type of insulin to Resident #3, which caused the resident's blood sugar level to drop. When RN #1 realized he administered the wrong type of insulin, he then tried to correct the error by administering the insulin he was supposed to have administered in the first place. Resident #3's MAR documented that the resident was supposed to receive 29 units of Lantus insulin. RN #1 drew up and administered 29 units of Humalog lispro insulin, instead of the long acting insulin. RN #1 recognized the medication and dosing error quickly and tried to correct the medication error by administering the Lantus long acting insulin on top of the administration of the quick acting insulin. -RN #1 made a decision to administer additional diabetic medication designed to further lower a person's blood glucose without consulting with the resident's physician. After the medications error occured RN #1 notified the DON and made a call to the physicians on call service. -The DON instructed RN #1 to prepare the resident and send her out to the emergency room; however, The investigation documented RN #1 failed to assess the resident health status and vital signs. There was no documented record of the resident blood glucose over time and no record of the resident vital signs including her heart rate, blood pressure or cognitive status. Instead RN #1 gave Resident #3 her blood glucose monitor and told the resident to test her own blood glucose and report any problems. The investigation documented upon consulting with the DON, RN #1 failed to follow the DON's instruction to send the Resident #1 to the emergency room for immediate assessment and treatment. RN #1 waited approximately four and a half hours before calling for EMS transport to send the resident to the emergency room. Resident #3 was transferred to the hospital for medical monitoring at approximately 12:00 a.m. -RN #1 failed to follow medication administration standards or physician orders and failed to follow facility protocol for treating a resident in a hypoglycemic state. The investigation documented, the facility conducted record reviews, and interviews. Education was provided to nursing staff on insulin administration. Medication carts were re-organized to separate the different types of insulin medications. Management also created an audit tool to monitor compliance and an audit was performed on all residents with diabetic medications to ensure accuracy and reflection in the resident care plan. Management identified gaps with RN#1 communication about the medication error, and the importance of the nurse monitoring blood sugar levels and seeking timely medical follow up. RN #1 was separated from employment at the facility. D. Record review Nursing note, dated 10/22/25 at 7:43 p.m., documented when the nurse (RN #1) finished administering the resident's evening medications, this nurse discovered that the resident's lispro insulin was on top of the medication cart. The note documented Resident #3 had received 29 units of Humalog lispro instead of 29 units of Lantus. This nurse immediately informed the resident of the error. The resident checked her own blood sugar, so she was given supplies and instructed to check her blood sugar every 29 minutes and report back to this nurse. The note documented she was also encouraged to start eating sugar rich foods. This nurse notified DON and called the on-call physician. The note documented RN #1 was to continue to monitor the resident. Nursing note, dated 10/22/25 at 8:49 p.m., documented Resident #3's blood sugar had varied from 60 mg/dL to 120 mg/dL. The note documented the nurse had not heard back from the on-call physician. The note documented RN #1 (continued on next page)

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F 0760 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	decided that if there was no return call from the on -call physician and the resident's blood sugar drops below 55 mg/dL, the resident would be sent to the emergency room.Nursing note, dated 10/22/25 at 10:53 p.m., documented Resident #3's blood sugar dropped to 54 mg/dL. The note documented the nurse had not heard from the on-call physician. The note documented RN #1 called non-emergent ambulance for transport to the emergency room. The note documented Resident #3 was so far asymptomatic.Nursing note, dated 10/22/25 at 11:58 p.m., documented RN #1 received a return call from the on-call physician. The physician gave the order to send Resident #3 to the emergency room. Hospital emergency room treatment note, dated 10/23/25, documented Resident #3 was admitted to the emergency room at 12:11 a.m. and was closely monitored for about five hours with every hour blood glucose checks. Resident #3 was diagnosed with hypoglycemia. The emergency room attempted to discharge the resident, however the resident's blood glucose was not able to be stabilized so the resident was admitted to the hospital for recurrent hypoglycemia. While in the hospital the resident's diabetic condition was monitored closely and her diabetic medications were adjusted for diabetes management. Review of the October 2025 CPO revealed the following physician's orders:Lantus solution 100 units per ml (insulin glargine) inject 13 units subcutaneously one time a day at 6:00 a.m. for diabetes, start date 10/1/25.Lantus solution 100 units per ml (insulin glargine) inject 29 units subcutaneously at bedtime for diabetes mellitus, start dated 10/1/25.Humalog (lispro insulin) solution, injection 100 units per ml per sliding scale: if the blood glucose is 150 - 200, give one unit; if 201 - 250 give two units; if 251 - 300 give three units; if 301 - 350 give four units; if 351 - 400 give five units, inject at 6:00 a.m., 11:00 a.m. and 4:00 p.m., before meals for diabetes; start date 10/19/23. The MAR documented the resident blood glucose results on 10/22/25 were documented as follows: -At 6:00 a.m. the resident's blood glucose was recorded as 120, no sliding scale lispro administered; -At 11:00 a.m., the resident's blood glucose was documented as 90 no, sliding scale lispro administered. -At 4:00 p.m., the resident's blood glucose was recorded as 201, two units of Humalog lispro insulin was administered per the sliding scale order; -At 7:33 p.m., the resident blood glucose result was not documented. RN #1 administered the incorrect type of insulin to the resident; -At 9:00 p.m. the resident's blood glucose was documented as 120.-Per the nursing note 10/22/25 at 10:53 p.m. the resident's blood glucose had dropped to 54 mg/dl. VI. Staff interviews The DON, the regional nurse consultant, the assistant director of nursing (ADON) and the NHA were interviewed together on 2/3/26 at 2:26 p.m. The DON said Resident #3 was administered the incorrect insulin by RN #1 on 10/22/25. The DON said she expected RN #1 would follow the facility emergency protocols for a mediation error and hypoglycemia and should have sent the resident to the emergency room for assessment and treatment right away. She said the nurse did not have to wait for the on-call physician to call back although the on-call physician.The DON said RN #1 did not call her back to report he did not send the resident immediately to the hospital and had not been in contact with the resident's physician's on call. The DON said she did not call RN #1 back that evening to check in on the resident status, as she expected the RN #1 to follow facility emergency procedures and protocol. The DON said that this occurrence resulted in a review with the leadership team. The DON said the team reviewed the diabetes protocol and emergency protocols with the facility medical director (MD) and made changes to the facility policy and procedure to ensure compliance with facility expectations and to safeguard the residents health. The DON said all nursing staff were educated on diabetes medication and diabetic management. The DON said RN #1 was placed on immediate suspension and later separated from the facility. RN #2 was interviewed on 2/3/26 at 5:21 p.m. RN #2 said she checked the physician's order before administering the medication to ensure the correct type and dose of insulin was administered. RN #2 said the facility now kept (continued on next page)

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F 0760 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	the long acting and quick acting insulin in separate compartments in the medication cart to help decrease medication errors. The medical director (MD) was interviewed 2/4/26 at 4:30 p.m. The MD said she had been the MD at the facility since April 2025. She said she was in the facility at least weekly and her staff nurse practitioner (NP) was in the facility two to three times weekly. She and the NP provide routine rounds at the facility and will also investigate a situation on the same day as needed. The MD said she was not notified about the insulin medication error to Resident #3 at the time the error occurred. She said she only learned of the error when she was asked to assess Resident #3 on 10/25/25; at the time the resident was admitted to the facility from her hospital stay related to the over dosing of insulin by RN #1.The MD said if she had been notified of the insulin related medication error at the time it occurred she would have asked the nurse to complete a full assessment of the resident's status including all vital signs, blood glucose, and other symptoms. Then she would have provided instruction for the nurse to have the resident transferred to the hospital, at the appropriate time. The MD said Resident #3 had a history of low blood sugars.The MD said in this situation, given the excessive amount of the incorrect insulin provided, the resident could be at cardiac risks as well as long term neurologic risks. The MD said that the facility staff can call her directly, if necessary. The MD said the on-call physician service can also call her directly if needed. She said she followed up with the on-call physicians if needed. The MD said the on-call physician services have reported to her that the facility did not always pick up the call when the on-call physician returns the facility's call. The MD said she completed a policy and protocol review with the facility staff after medication error occurred to Resident #3 which resulted in providing routine glucagon protocols for residents with diabetes and improved monitoring of hypoglycemic symptoms.

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F 0940 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	Develop, implement, and/or maintain an effective training program for all new and existing staff members. Based on record review and interviews, the facility failed to provide, implement and maintain an effective training program for new and existing staff. Specifically the facility failed to provide:-All staff the required annual abuse identification, abuse prevention and abuse reporting training, for 75 out of 83 staff; -All staff dementia management training, for 39 out of 83 staff;-All staff resident rights training, for 31 out of 83 staff; -All staff quality assurance and performance improvement (QAPI) training, for 30 out of 83 staff;-All direct care staff effective communication training, for 49 out of 49 staff; -All staff infection control training, for 20 out of 83 staff members; -All staff compliance and ethics training, for 16 out of 83 staff; and, - All direct care staff behavioral health training, for 13 out of 49 staff. Findings include:I. Facility policy and procedureThe In-Service Training policy, revised April 2021, was provided by the nursing home administrator (NHA) on 2/4/26 at 1:28 p.m. The policy read in pertinent part, All staff must participate in initial orientation and annual in-service training. Required training topics included effective communication, resident rights, preventing abuse,facility QAPI program, infection prevention, behavioral health, and compliance and ethics. II. Staff training recordsOn 2/4/26 a request was made for the facility's staff training records for all active staff members. The records revealed the facility failed to meet the minimum training requirements.The records revealed 39 staff members did not complete the facility's dementia training. No other documentation was provided such as in service training.The records revealed 31 staff did not complete the safeguarding resident rights training. The facility did provide an in service training document, however no sign in sheet was provided.The records revealed 30 staff did not complete QAPI training. The facility provided an in-service training document, as well as a sign in sheet containing all of the staff who had completed this requirement. The records revealed no direct care staff members completed the effective communication training. A copy of the training itself was provided, however no documentation of it being used was able to be provided.The records revealed 20 staff members did not complete infection prevention training requirements. 36 were documented to have completed the online version of the training and 27 were found to have completed the in service training. In-service training was provided and sufficiently covered the topic area.The records revealed 16 staff members did not complete compliance and ethics rights training. Although all staff members were listed on this online training, many did not have a completion date listed. A copy of the training itself was provided, however no documentation of it being used was provided.The records revealed 13 staff members had also not completed the required online behavior training. No other documentation was provided such as in service training.II. Staff interviewsThe NHA and the assistant director of nursing (ADON) were interviewed on 2/4/26 at 10:42 a.m. The NHA said most training was done during the onboarding process. She said about 91 percent of the trainings had been completed and all of the abuse and dementia care trainings were finished. The NHA said they often had lunch and learns for their less tech savvy staff. The NHA said this information was not documented.-However, record review revealed the training had not been completed (see record review above).The NHA, the regional nurse consultant, director of nursing (DON) and the ADON were interviewed on 2/4/26 at 5:39 p.m. The NHA said there were some staffing barriers in getting staff to complete all required trainings. The NHA said this included some staff being part time and lack of time for training when the facility needed staff on the floor to provide care to the residents.The NHA said they were planning on scheduling dedicated training time for those behind on completing required training sessions. The NHA said she felt like the training they pulled was incorrect and thought more staff completed training, however she was not able to locate additional records to prove exactly what staff (continued on next page)

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F 0940 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	were trained on and who attended. The NHA said going forward facility leadership planned to complete a log for training to keep on track, as well as scheduling sessions for staff to work on training. The NHA said leadership planned to start this process now and be up to date with all required and needed training components by 6/1/26. The NHA said in the meantime she planned to prioritize the most important training for completion.The regional nurse consultant said the facility's current training plan was not effective to make sure all staff were sufficiently trained as required and she was recommending the facility use the industry approved training platform to ensure compliance.

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F 0943 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	Give their staff education on dementia care, and what abuse, neglect, and exploitation are; and how to report abuse, neglect, and exploitation. Based on record review and interviews, the facility failed to provide training to their staff that at a minimum educates staff on activities that constitute abuse, neglect, exploitation and misappropriation of resident property as set forth, procedures for reporting incidents of abuse, neglect, exploitation or misappropriation of resident property and resident abuse prevention.Specifically the facility failed to provide 75 of 83 staff members annual training on abuse identification, prevention, reporting and evidence gathering. Findings include:I. Facility policy and procedureThe Abuse policy, revised April 2021, was provided by the nursing home administrator (NHA) on 2/4/26 at 1:28 p.m. The policy read in pertinent part, The facility's resident abuse, neglect and exploitation prevention program consists of a facility-wide commitment and resource allocation to support abuse prevention, identification and response. This included Provid[ing] staff orientation and training programs that include topics such as abuse prevention, identification and reporting of abuse, stress management, and handling verbally or physically aggressive resident behavior. II. Staff training recordsA request was made for the facility's current training records for annual abuse and dementia training on 2/4/26. The records provided failed to demonstrate that facility staff were provided with a thorough abuse training that included abuse identification of all types of abuse; steps and measures to prevent abuse and neglect by staff to resident and techniques to prevent resident to resident altercation; requirements for timely reporting of abuse reporting; and methods of gathering evidence for a thorough and complete investigation.-The records revealed that 75 of 83 total facility staff were not provided annual abuse training as required since 2024. III. Staff interviewsThe NHA and assistant director of nursing (ADON) were interviewed on 2/4/26 at 10:42 a.m. The NHA said most training was done during the onboarding process. She said all staff had been provided abuse and dementia care trainings and they were finished providing each training.-However, record review revealed 75 out of 83 staff members had not received annual abuse training. The NHA said the last time the facility provided an extensive training on abuse prevention was in 2024.