STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	065153	A. Building B. Wing	06/03/2026

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Vista Grande Rehabilitation and Healthcare Center	680 E Hospital Dr Cortez, CO 81321

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 0600 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Protect each resident from all types of abuse such as physical, mental, sexual abuse, physical punishment, and neglect by anybody. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on interviews and record review, the facility failed to ensure residents were kept free from abuse for one (#2) of two residents reviewed for abuse out of 36 sample residents. Specifically, the facility failed to protect Resident #2 from sexual abuse by Resident #73 on 12/11/25.Findings include: I. Facility policy and procedureThe Resident Right to Freedom from Abuse, Neglect and Exploitation policy and procedure, revised 2025, was provided by the nursing home administrator (NHA) on 5/31/26 at 2:55 p.m. It read in pertinent part, The facility shall have and implement written policies and procedures to prevent and prohibit all types of abuse, neglect, misappropriation of resident property and exploitation. The facility shall monitor the resident including the identification, ongoing assessment, care planning for appropriate interventions and monitoring of residents with needs and behaviors which might lead to conflict or neglect such as sexually aggressive behavior such as saying sexual things and inappropriate touching and grabbing. Identify, correct and intervene in situations in which abuse, neglect, exploitation and or misappropriation of resident property is more likely to occur.II. Incident of sexual abuse of Resident #2 by Resident #73 on 12/11/25 A. Facility investigation The 12/11/25 summary of investigation revealed the allegation was substantiated. The summary documented that video surveillance revealed Resident #73 summoned Resident #2 over. Resident #2 went to Resident #73 and they held hands at the table. Resident #2 talked to Resident #73. Resident #73's response was mumbled and Resident #2 could not understand what he said. Resident #73 stroked Resident #2's sweater and her breast on top of her clothing. Resident #73 did not grab Resident #2. Resident #2 grabbed Resident #73's hand and moved it back to the table. Resident #2 held Resident #73's hand for a few more seconds and then moved to another table to eat her breakfast. Resident #2 reported the incident to a nurse after breakfast. There were two staff members in the dining room and they saw Resident #2 and Resident #73 holding hands but neither saw Resident #73 touching Resident #2's breast. The 12/11/25 facility report revealed the brief summary of the allegation was Resident #2 reported to registered nurse (RN) #2 at approximately 8:30 a.m. that Resident #73 touched her breast while they were in the dining room. The immediate intervention was to separate the residents and 15 minute checks were implemented for Resident #73. Resident #2's statement was completed on 12/11/25. It revealed Resident #2 went to the kitchen and Resident #73 waved Resident #2 to come over. Resident #2 went over and Resident #73 put his hands out. Resident #2 put her hands on his hands. Resident #73 was rubbing Resident #2's hands. Resident #73 took and looked at her hands. Resident #73 touched Resident #2's sweater and put his hand and rubbed down on her. Resident #2 shook her hand no and left. Resident #2 went down to the table to sit at the table. Dietary aide #1 brought Resident #2 her food. Resident #2 told dietary aide #1 thank you for getting me out of the situation. Resident #2 ate her breakfast and left the dining room and talked to RN #2. Dietary aide #1's witness statement was completed on 12/11/25. Dietary aide #1 said she was in the dishroom when Resident #2 went into the kitchen. Dietary aide #1 came out of the dishroom and she saw Resident #2 and Resident #73 holding hands. The residents were not talking. Dietary aide #1 said Resident #73 tried to pull her closer but the table was in the way. Dietary aide #1 (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

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F 0600 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	required set up assistance with eating and substantial assistance with oral hygiene and toileting. He was dependent on showering.The assessment revealed the resident did not exhibit behaviors towards others. 2. Record review The attention-seeking care plan, initiated 3/15/23 and revised 2/13/26, revealed Resident #73 had behaviors of inappropriately touching others. Interventions included if he tried to hold hands with others, staff were to remind him to keep his hands to himself; administering medication per physician's orders, approaching him in a calm manner to avoid frustration and behavior escalation, attempting to redirect the resident when he was exhibiting behaviors, encouraging the resident to participate in activities, giving non-judgmental support, monitoring and documenting episodes of inappropriate behaviors and providing a structured schedule for daily care when possible.The 12/11/25 change in condition nurse progress note revealed staff reported Resident #73 inappropriately touched another resident (Resident #2). The physician was notified and gave new orders for finasteride and medroxyprogesterone (medications that are sometimes used to decrease hypersexual behavior). The resident's representative was notified and verbal consent was provided for the medications. The director of nursing (DON) and the NHA were made aware of the incident. III. Staff interviewCertified nurse aide with medication authority (CNA-Med) #2 was interviewed on 6/2/26 at 3:17 p.m. CNA-Med #2 said he reported abuse to the nurse on duty and management including the NHA and the DON. He said when he saw abuse, he separated the residents and made sure the residents were safe before reporting the abuse allegation to the nurse. CNA-Med #2 said he told the nurse and the nurse started the investigation. CNA-Med #2 said the incident was documented as a progress note and as behavior monitoring in the residents' medication administration records (MAR). He said a plan of action was made right away and was documented in the residents' charts to include what interventions were put in place. He said some interventions were keeping residents separated, offering activities they liked to do and monitoring for pain. CNA-Med #2 said interventions were documented in shift report, a communications book, and alert charting.CNA-Med #2 said he knew what escalated a resident's sexual behavior by getting to know them when they were first admitted . He said when behaviors were observed, he told the nurse and charted. CNA-Med #2 said he knew what de-escalated a resident's sexual behavior by finding the right staff member to care for the resident and educating the resident not to do it because it was not appropriate. He said some residents were always flirty, so he charted and staff knew the behavior. CNA-Med #2 said he knew if a resident had sexual behaviors because it was in the care plan, the progress note and the MAR. CNA-Med #2 said there were residents who had sexual behaviors. He said he was familiar with Resident #73. He said he never saw him exhibit any sexual behaviors with other residents, including Resident #2. RN #1 was interviewed on 6/2/26 at 3:46 p.m. RN #1 said she reported abuse to the DON and the NHA. She said if she saw abuse, she separated the residents, entered a progress note, notified the physician and the resident's representative. She said a progress note indicated what interventions were in place and said 15-minute checks were one intervention. RN #1 said residents were monitored post-incident for 24 hours. RN #1 said she knew what escalated a resident's sexual behavior based on the resident's diagnoses. She said some residents had dementia and when they sundowned (a state of late day confusion, anxiety and agitation related to dementia) they exhibited behaviors. RN #1 said residents did not understand and did not have awareness of the behaviors, so it was important to explain why they could not do what they wanted to do. RN #1 said interventions to de-escalate a resident's behavior was documented as a health status note. RN #1 said she was familiar with Resident #73 and said 15-minute checks and medications were added to decrease his sexual behavior. She said redirection and telling him not to do the behavior were interventions to prevent the sexual behavior. RN #1 said she was the nurse who Resident #2 reported the sexual abuse from Resident #73. She said the residents were both in the dining room and Resident #2 approached Resident #73. RN #1 said Resident #73 touched her arm and then went up to brush her breast. RN #1 said the event scared Resident #2. The NHA, the DON and the social services director (SSD) were interviewed together on 6/2/26 at 5:05 p.m. The NHA said she was the abuse coordinator (continued on next page)

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