| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: | (X2) MULTIPLE CONSTRUCTION | (X3) DATE SURVEY COMPLETED |
|---|---|---|---|
| | 065253 | A. Building<br>B. Wing | 12/18/2025 |

| NAME OF PROVIDER OR SUPPLIER | STREET ADDRESS, CITY, STATE, ZIP CODE |
|---|---|
| LA Villa Grande Care Center | 2501 Little Bookcliff Dr<br>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<br><br>Level of Harm - Immediate jeopardy to resident health or safety<br><br>Residents Affected - Few<br><br>Note: The nursing home is disputing this citation. | Ensure that residents are free from significant medication errors.<br><br>(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 0760<br><br>Level of Harm - Immediate jeopardy to resident health or safety<br><br>Residents Affected - Few<br><br>Note: The nursing home is disputing this citation. | **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on record review and interviews, the facility failed to prevent a significant medication error for warfarin (a blood thinner medication) for one (#8) of three residents reviewed for medication errors out of 10 sample residents. Specifically, the facility failed to prevent a significant medication error when Resident #8 received warfarin, a blood-thinning medication, twice a day (once in the morning and once in the evening), instead of once a day at bedtime.Resident #8 was admitted on [DATE] and discharged to home on 9/22/25. Resident #8's diagnoses included hypertension, kidney disease, diabetes, stroke, and left-sided paralysis. Resident #8 was admitted to the facility from the hospital with stroke treatment and prevention orders for warfarin and laboratory monitoring of the blood level international normalized ratio (INR), which is used to monitor the ability for blood to clot. Resident #8's admitting physician's orders on 8/25/25 included testing of the INR on 8/26/25 and warfarin 1 milligram (mg) in the morning and monitoring the INR daily for warfarin dose titrations. A review of Resident #8's electronic medical record (EMR) revealed on 8/22/25 that the resident's INR level tested at the hospital before discharge was 2.44.On 8/26/25, Resident #8's INR level was tested, and the result was 1.69. The result was forwarded to the physician's office. On 8/27/25, the physician gave a verbal telephone order to the facility nurse for warfarin 1.5 mg, by mouth, one time a day, in the evening. The physician gave an order to document the resident's most recent INR level in Resident #8's medication administration record (MAR) and to draw the next INR level on 8/29/25. The 8/27/25 verbal physician's order did not include an order to discontinue the resident's previous 1 mg warfarin dose, which had been administered in the morning. As a result, Resident #8 received warfarin in the morning and in the evening from 8/28/25 to 9/9/25.Additionally, a review of Resident #8's EMR revealed that facility nurses failed to document the resident's most recent INR level from 8/26/25 and instead reported the 8/22/25 hospital result of 2.44 from 8/28/25 to 9/9/25. On 9/10/25, Resident #8's INR level was checked, and the result was 4.5. The physician gave new orders to hold the warfarin medication for three days and recheck the INR level on 9/15/25. The facility's failure to monitor Resident #8's warfarin dosages and INR levels resulted in a significant medication error, which placed Resident #8 at risk for a likely serious outcome. Serious harm to Resident #8 was likely to have occurred as a result of the significant medication error.Findings include:Record review and interviews confirmed the facility corrected the deficient practice prior to the onsite investigation from 12/15/25 to 12/18/25, resulting in the deficiency being cited as past noncompliance with a correction date of 9/11/25. I. Situation of serious harmResident #8's admitting physician orders on 8/25/25 included testing of the INR on 8/26/25 and warfarin 1 mg in the morning and monitoring the INR daily for warfarin dose titrations. A review of Resident #8's electronic medical record (EMR) revealed on 8/22/25 the resident's INR level tested at the hospital before discharge was 2.44.On 8/26/25 Resident #8's INR level was tested and the result was 1.69. The result was forwarded to the physician's office. On 8/27/25, the physician gave a verbal telephone order to the facility nurse for warfarin, by mouth 1.5 mg, one time a day, in the evening. The physician gave an order to document the most recent INR level in Resident #8's MAR and to draw the next INR level on 8/29/25. The 8/27/25 verbal physician's order did not include an order to discontinue the resident's previous 1 mg warfarin dose, which had been administered in the morning. As a result, Resident #8 received warfarin in the morning and in the evening from 8/28/25 to 9/9/25.Additionally, a review of Resident #8's EMR revealed that facility nurses failed to document the resident's most recent INR level from 8/26/25 and instead documented the 8/22/25 hospital result of 2.44 from 8/28/25 to 9/9/25. On 9/10/25, Resident #8's INR level was checked, and the result was 4.5. The physician gave new orders to hold the warfarin medication for three days and recheck the INR level on 9/15/25. The facility's failure to monitor Resident #8's warfarin dosages and INR levels resulted in a significant medication error and placed Resident #8 at risk for a likely serious outcome. II. Facility plan of correctionThe corrective action plan the facility implemented in response to Resident #8's significant medication error was provided by the director of nursing (DON) on 12/17/25 at 9:05 a.m. The plan documented the following:A. Immediate actionResident #8 was evaluated by the outpatient clinic on 9/10/25. Resident #8 had an INR level tested on [DATE] with a result of 4.5. The physician gave new orders to hold the warfarin for three days, restart the warfarin on 9/14/25, and repeat INR testing on 9/15/25 in the morning. The INR result on 9/15/25 will determine the next steps for warfarin therapy.The facility completed a change in condition assessments for Resident #8 from 9/10/25 to 9/13/25 and determined Resident #8 had no adverse outcome after taking the additional warfarin |