STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	065331	A. Building B. Wing	08/21/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Larchwood Inns	2845 N 15th St Grand Junction, CO 81506

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 0627 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure the transfer/discharge meets the resident's needs/preferences and that the resident is prepared for a safe transfer/discharge. (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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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0627 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	**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 seven sample residents. Specifically, the facility failed to:-Allow Resident #2 to return to the facility after an unplanned discharge to the hospital;-Provide documentation made by Resident #2'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 #2 for readmission after he was stabilized at the hospital and ready to return to the facility.Findings include:I. Facility policy and procedureThe Transfer or Discharge, Facility-Initiated policy, revised October 2022, was provided by the assistant director of nursing (ADON) on 8/21/25 at 11:31p.m. The policy read in pertinent part, Once admitted to the facility, residents have the right to remain in the facility. Facility-initiated transfers and discharges, when necessary, must meet specific criteria and require resident/representative notification and orientation, and documentation as specified in this policy. Each resident will be permitted to remain in the facility and not be transferred or discharged unless;-The transfer discharge is necessary for the resident's welfare and the resident's needs can not be met in this facility; and,-The safety of individuals in the facility is endangered due to the clinical or behavioral status of the resident. Residents who are sent emergently to an acute care setting, these scenarios are considered facility initiated transfers, not discharges, because the residents return is generally expected. Residents who are sent emergently to an acute care setting, such as a hospital, are permitted to return to the facility. If discharge is initiated by the facility after an emergent transfer to the hospital, the reason for the discharge is based on the resident status at the time the resident seeks to return to the facility and not at the time the resident was transferred to acute care. Should a resident be transferred or discharged for any reason, the following information is communicated to the receiving facility or provider: The specific resident needs that can not be met; the facilities attempt to meet those needs; and, the receiving facilities services that are available to meet those needs. Should the resident be transferred to discharge for any of the following reasons, the basis of the transfer or discharge is documented in the resident's clinical record by the resident's attending physician. The transfer discharge is necessary for the residents welfare and the resident's needs cannot be met in the facility. Should the resident be transferred or discharged for any reasons the basis of the transfer discharge will be documented in the resident's clinical record by a physician, the safety of the individuals of the facilities endangered due to the clinical behavior status of the resident or the health of the individuals in the facility would otherwise be endangered. If the facility determines that the resident can not return to the facility, the medical record would indicate that the facility made efforts to determine if the resident still required the services of the facility and was eligible for Medicare skilled nursing facility or Medicaid nursing facility services; ascertain an accurate status of resident's condition, which can be accomplished via communication between the hospital and facility staff and/or through visits by the facility staff to the hospital; find out from the hospital the treatments, medications and the services the facility would need to provide to meet the residents needs upon returning to the facility. If the facility is unable to provide the treatments, medications, and services needed, the facility may not be able to meet the residents needs; and work with the hospital to ensure the residence condition needs are within the facility's scope of care, based on its facility assessment prior to the hospital discharge.II. Resident statusResident #2, age greater than 65, was admitted on [DATE] and discharged to the hospital on 7/31/25. According to the July 2025 computerized physician orders (CPO), diagnoses included non-traumatic acute subdural hemorrhage, reduced mobility, mild cognitive impairment of uncertain or unknown etiology, repeated falls, need for assistance with personal care, unspecified lack of coordination and generalized muscle weakness.The 7/15/25 minimum data set (MDS) assessment identified Resident #2 was cognitively intact with a brief interview for mental status (BIMS) score of 15 out of 15. The MDS assessment indicated the resident required partial to moderate physical assistance for transferring from surface to surface, bed mobility and walking. The MDS assessment documented Resident #2 used a motorized wheelchair. III. Resident representative interviewResident #2's representative was interviewed on 8/20/25 at 5:10 p.m. The representative said Resident #2 was initially admitted to the facility from the hospital after a fall, for therapy and long-term placement. He said Resident #2 was sent back to the hospital two weeks later. He said he was told that Resident #2 was sent to the hospital related to a fall at the facility. He

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F 0628 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide the required documentation or notification related to the resident's needs, appeal rights, or bed-hold policies. (continued on next page)

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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 0628 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on record review and interviews, the facility failed to revise and implement an effective discharge plan for one (#2) of three residents reviewed for discharge planning out of seven sample residents.Specifically, the facility failed to:-Ensure the discharge planning was process was documented, including the reason for discharge in Resident #2's electronic medical record (EMR); -Notify Resident #2 and/or Resident #2's representative, in writing, of the discharge, including the reason for the move, the effective date of discharge, the location where the resident was being discharged to, a statement of the resident's appeal rights and the name, address and telephone number of the office of the state long term care ombudsman; and,-Notify the facility's ombudsman of Resident #2's discharge in writing in a timely manner.Findings include: I. Facility policy and procedureThe Transfer or Discharge, Facility-Initiated policy, revised October 2022, was provided by the assistant director of nursing (ADON) on 8/21/25 at 11:31p.m. The policy read in pertinent part, Once admitted to the facility, residents have the right to remain in the facility. Facility initiated transfers and discharges, when necessary, must meet specific criteria and require resident/representative notification and orientation, and documentation as specified in this policy. Each resident will be permitted to remain in the facility and not be transferred or discharged unless;-The transfer discharge is necessary for the resident'swelfare and the resident's needs can not be met in this facility; and,-The safety of individuals in the facility is endangereddue to the clinical or behavioral status of the resident. Residents who are sent emergently to an acute care setting, these scenarios are considered facility-initiated transfers, not discharges, because the residents return is generally expected. Residents who are sent emergently to an acute care setting, such as a hospital, are permitted to return to the facility. If discharge is initiated by the facility after an emergent transfer to the hospital, the reason for the discharge is based on the resident status at the time the resident seeks to return to the facility and not at the time the resident was transferred to acute care. If the facility does not permit a resident's return to the facility based on the inability to meet the resident's needs, the facility will notify the resident, and or his or her representative in writing of the discharge, including notification of appeal rights. The facility will send a copy of the discharge notice to a representative of the Office of the State LTC Ombudsman. The notice of theOffice of the State LTC Ombudsman will occur at the same time the notice of discharge is provided to the resident and the resident representative. If the resident chooses to appeal the discharge, the facility will not discharge residents while the appeal is pending. Should a resident be transferred or discharged for any reason, the following information is communicated to the receiving facility or provider: The specific resident needs that can not be met; the facilities attempt to meet those needs; and, the receiving facilities services that are available to meet those needs. When a resident is transferred or discharged from the facility, the following information is documented in the medical record: the basis of the transfer of the discharge; if the resident is being transferred or discharged because of his or needs can not be met at the facility the documentation would include the specific resident needs that can not be met; the facility's attempt to meet those needs; the receiving facilities services that are available for those needs; That an appropriate notice was provided to the resident and/or legal representative; the date and the time of the transfer or discharge; the new location of the resident; the mode of transportation; a summary of the resident overall medical physical and mental condition. Should the resident be transferred or discharged for any of the following reasons, the basis of the transfer or discharge is documented in the resident's clinical record by the resident's attending physician. The transfer discharge is necessary for the resident's welfare and the resident's needs can not be met in the facility. Should the resident be transferred or discharged for any reasons the basis of the transfer discharge will be documented in the resident's clinical record by a physician, the safety of the individuals of the facilities endangered due to the clinical behavior status of the resident or the health of the individuals in the facility would otherwise be endangered. II. Resident status Resident #2, age greater than 65, was admitted on [DATE] and discharged to the hospital on 7/31/25. According to the August 2025 computerized physician orders (CPO), diagnoses included non-traumatic acute subdural hemorrhage, reduced mobility, mild cognitive impairment of uncertain or unknown etiology, repeated falls, need for assistance with personal care, unspecified lack of coordination and generalized muscle weakness. The 7/15/25 minimum data set (MDS) assessment identified Resident #2 was cognitively intact with a brief interview for mental status (BIMS) score of 15 out of 15. The MDS assessment indicated the resident required partial to moderate