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	12/05/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Larchwood Inn	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 0580 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Immediately tell the resident, the resident's doctor, and a family member of situations (injury/decline/room, etc.) that affect the resident. (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 0580 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 periodically update resident contact information for one (#2) out of three residents reviewed out of five sample residents.Specifically, the facility failed to obtain and Resident #2's power of attorney's (POA) phone number. Findings include:I. Resident #2A. Resident statusResident #2, age greater than 65, was admitted on [DATE]. According to the September computerized physician orders (CPO), diagnoses included history of a motor vehicle accident, fracture of the right pubis, fracture of the sacrum, fracture of the fifth lumbar vertebra, anemia, hypothyroidism and hypertension.The 9/23/25 minimum data set (MDS) assessment revealed Resident #2 had moderate cognitive impairment with a brief interview for mental status (BIMS) score of ten out of 15. Resident #2 was independent with oral care. She required supervision and cues with toileting, dressing, and personal hygiene. Resident #2 required substantial assistance with footwear.B. Record reviewThe power of attorney declaration form, dated 7/15/25, revealed Resident #2's POA changed from her daughter to her son. -However, review of Resident #2's electronic medical record (EMR) on 10/1/25 at 2:00 p.m. did not reveal the resident's POA's contact information.C. Staff interviewsThe social service director (SSD) was interviewed on 10/1/25 at 3:00 p.m. The SSD said she was unable to find the phone number for Resident #2's POA in the EMR. The SSD said she started working for the facility in June 2025. She said Resident #2's son visited often and received in person updates, but the SSD said she would not be able to call Resident #2's POA if an emergency occurred. The SSD said she would try the contact information of the daughter (who was no longer the POA) listed in the Resident #2's electronic medical record. Registered nurse (RN) #2 was interviewed on 10/1/25 at 3:22 p.m. RN #2 said she was not able to find the phone number for Resident #2's son/POA in the EMR. RN #2 said she saw Resident #2's son earlier today and RN #2 said she would have updated the contact information if she was aware it was missing. RN #2 said if Resident #2 had an emergency, she would have to try to contact the other family since she did not have any way to contact the resident POA.The nursing home administrator (NHA) and the director of nursing (DON) were interviewed on together on 10/1/25 at 5:01 p.m. The NHA and the DON confirmed the phone number for the POA was not in the EMR. The NHA said the son and the daughter members were in dispute of who should have POA for Resident #2. The NHA said she remembered a new POA form was completed in July 2025 and the phone number was probably missed when updating the information. The NHA said he contacted the staff member assigned to medical records. The NHA said the staff member reviewed Resident #2's EMR and was not able to find the phone number for the POA. The NHA said she planned to find the contact information and include the phone number in the EMR as soon as possible.The NHA was interviewed again on 10/1/25 at 5:36 p.m. The NHA said the resident's POA information was added to the EMR. the medical record. The NHA and the MDS coordinator were interviewed together on 10/1/25 at 6:02 p.m. The MDS coordinator said having the phone number for the new POA was important because staff needed to be able to contact him in case of an emergency. The MDS coordinator said the new POA for Resident #2 did not call often, but did visit in person frequently. The MDS coordinator said typically, the SSD or the social services assistant would obtain and enter the contact information on admission or on request. The MDS coordinator said she thought the phone number was missed when the facility received new paperwork assigning a new resident representative. The MDS coordinator said the SSD had just started at the facility around the time they received the new POA declaration form, and she may not have known at the time that it was her responsibility to update the facesheet.

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F 0585 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Honor the resident's right to voice grievances without discrimination or reprisal and the facility must establish a grievance policy and make prompt efforts to resolve grievances. (continued on next page)

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F 0585 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 interviews and record review, the facility failed to ensure one (#1) of three residents out of six sample residents received prompt efforts to resolve grievances. Specifically, the facility failed to timely address, communicate and attempt to resolve concerns related to not receiving a hair cut for Resident #1. Finding include:I. Facility policy and procedureThe Grievance/Complaints, Filing policy, revised April 2017 was provided by the assistant director of nursing (ADON) on 10/1/25 at 5:58 p.m. The policy read in part, Residents and their representatives have the right to file grievances, either orally or in writing, to the facility staff or to the agency designated to hear grievances. The administrator will make prompt efforts to resolve grievances to the satisfaction of the resident and or representative. Grievances and/or complaints may be submitted orally or in writing, and maybe filed anonymously. Upon receipt of the grievance and/or complaint, the grievance officer will review the and review and investigate the allegations and submit a written report of such findings to the administrator within five working days of receiving the grievance and/or complaint. The administrator will review the findings with the grievance officer to determine what corrective actions, if any, need to be taken. The resident or person filing the grievance and/or complaint on behalf of the resident, will be informed verbally and in writing of the findings of the investigation and the actions that will be taken to correct any identified problems.The Grievance/Complaints, Recording and Investigating policy, revised April 2017 was provided by the ADON on 10/1/25 at 5:58 p.m. The policy read in part, All grievances and complaints filed with the facility will be investigated and corrective actions will be taken to resolve the grievances. Upon receiving a grievance and complaint report the grievance officer will begin an investigation into the allegations. The grievance officer will record and maintain all grievances and complaints on the resident grievance complaint log. The resident grievance/complaint investigation report will be filed with the administrator within five working days of the incident. II. Resident #1Resident #1, age greater than 65, was admitted on [DATE]. According to the October 2025 computerized physician's orders (CPO), diagnoses included Alzheimer's disease with late onset, dementia and other diseases classified elsewhere, unspecified severity and dysphasia.The 7/24/25 minimum data set (MDS) assessment revealed Resident #1 had short and long term memory problems. A staff assessment identified her cognition was severely impaired. According to the MDS assessment. Resident #1 was rarely to never able to understand others or make herself understood. She was dependent on staff for all activities of daily living (ADL) and used a wheelchair. III. Resident representative interviewResident #1's representative was interviewed on 10/1/25 at 2:37 p.m. The representative said Resident #1 kept her hair short and she was scheduled for a hair cut every six weeks at the facility but then the hair cuts stopped. She said for months, she requested to have Resident #1's hair cut. She said the only communication she received was that if a resident was in a wheelchair, the resident would not be able to get a haircut until the facility hired a new beautician. The representative said she brought up the need for a hair cut during care conferences and with any staff member she spoke with. She said it took four months and her getting upset with staff in order for Resident #1 to get a hair cut. IV. Record reviewThe mobility and self-care deficit care plan interventions identified Resident #1 was dependent on staff for her personal hygiene, used a Broda chair (specialty wheelchair) for mobility that staff propels and bolster foot positioning device, and required the use of a hoyer lift to transfer from surface to surface (7/29/25).The 7/7/25 social service note documented Resident #1's representative requested during care conference that Resident #1 was placed on a consistent haircut schedule every six to seven weeks. -However, there was no documentation indicating the resident was placed on a consistent haircut schedule until September 2025.A 9/3/25 concern/grievance form was provided by the ADON on 10/1/25 at 5:58 p.m. The grievance card created by Resident #1's representative on 9/3/25. According to the grievance card, Resident #1 had been waiting for a hair cut for four months. The 9/3/25 nursing note documented the nursing home administrator (NHA) met with Resident #1's representative on 9/3/25 her concerns about Resident #1's hair being too long. According to the note, the NHA informed the representative that they have hired a new beautician who should be starting shortly.The 9/4/25 nursing note documented the beautician would cut Resident #1's hair when she arrived for duty after her facility onboarding. According to the note, the NHA was notified of the representative's concerns on 9/2/25 and contacted the representative. The note indicated the social service director (SSD) was already helping her resolve the concerns.V. Staff interviewThe facility's beautician was interviewed on 10/1/25 at 3:20 p.m. She said the Resident #1 was placed on a every four

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F 0791 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide or obtain dental services for each resident. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observations, record review and interviews, the facility failed to ensure two (#2 and #1) of three residents out of five sample residents received dental services timely.Specifically, the facility failed to:-Identify and refer Resident #2 to the dentist timely after she lost her left upper canine tooth; and, -Resident #1 was offered routine dental care. Findings include: I. Facility policy and procedure The Emergency Dental Care policy, revised April 2007, was provided by the assistant director of nursing (ADON) on 10/1/25 at 6:49 p.m. It revealed in pertinent part, Emergency dental care is available on a twenty-four hour basis. Should a resident need emergency dental care, the dental consultant shall be notified so that arrangements for the emergency care can be made. Social services shall contact the consultant dentist to set up the appointment. (Note: Should social services be unavailable, the charge nurse shall contact the consultant dentist.) Emergency dental services included to treat an episode of acute pain in teeth, gums, or palate, broken, or otherwise damaged teeth, or any problem of the oral cavity appropriately treated by a dentist that requires immediate attention. II. Resident #2 A. Resident status Resident #2, age greater than 65, was admitted on [DATE]. According to the October 2025 computerized physician orders (CPO), diagnoses included history of a motor vehicle accident, fracture of the right pubis, fracture of the sacrum, fracture of the fifth lumbar vertebra, anemia, hypothyroidism and hypertension. The 9/23/25 minimum data set (MDS) assessment revealed Resident #2 had moderate cognitive impairment with a brief interview for mental status (BIMS) score of ten out of 15. Resident #2 was independent with oral care. She required supervision and cues with toileting, dressing, and personal hygiene. Resident #2 required substantial assistance with footwear. B. Resident interview and observations Resident #2 was interviewed on 10/1/25 at 11:18 a.m. Resident #2 said she thought her tooth fell out about a month ago. Resident #2 said no accident occurred, the tooth just fell out while she was eating. Resident #2 said she told a staff member the tooth fell out and even kept the tooth for a little while to show them. Resident #2 said sometimes the staff helped her brush her teeth and sometimes she was able to brush them herself. Resident #2 said she also thought she told her daughter about her tooth. During the interview, it was observed the Resident #2 was missing her left canine tooth. (continued on next page)

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F 0791 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	C. Resident #2's representative interview Resident #2's representative was interviewed on 10/1/25 at 3:47 p.m. She said Resident #2 showed the representative her tooth sitting on her bedside table when she visited Resident #2 on 9/4/25. She said at first Resident #2 wanted to see her dentist, but about a week later Resident #2 told her she did not want to go anymore. The resident's representative said she called the facility to ask about what dental services they offer inside the facility, but did not report the tooth had fallen out during the phone call. The resident's representative said she would have wanted somebody to assess Resident #2's mouth and intervene if there was an infection or some other issue. D. Record review Resident #2's activities of daily living (ADL) care plan, initiated 6/20/25 and revised 7/9/25, revealed Resident #2 had deficits related to multiple fractures. Interventions related to oral care revealed Resident #2 required moderate to dependent on one staff assist with oral care in order to maximize independence. Resident #2's certified nurse assistant (CNA) Kardex (staff directive tool), dated 10/1/25, revealed Resident #2 required moderate to dependant assistance with oral care. Review of Resident #2's CNA task list for oral care, dated from 9/1/25 through 10/1/25, revealed Resident #2 required a range from substantial assistance to set up and clean up assistance only. -Review of Resident #2's electronic medical record (EMR) did not reveal documentation regarding the resident's missing tooth, despite documentation indicating the staff had assisted the resident with oral care. -Review of Resident #2's photo in the EMR revealed the resident had both canines at the time of the photo (see observations above). E. Staff interviews Registered nurse (RN) #2 was interviewed on 10/1/25 at 3:22 p.m. RN #2 said she was informed a few minutes ago that Resident #2 was missing a tooth, but did not now Resident #2 lost a tooth prior to this shift. RN #2 said any staff member who found a missing tooth in a resident's room or any potential injury without a known origin should report what they found to the nurse assigned to that room so the nurse can follow up. RN #2 said the nurse should complete an assessment to make sure there were no infections or complications requiring a change in the care plan. RN #2 said she planned to complete an oral assessment after the interview. CNA #2 was interviewed on 10/1/25 at 5:29 p.m. CNA #2 said She said they were able to see which residents need assistance with ADLs and transferring based on the whiteboard with a privacy cover for each resident in the room. CNA #2 said Resident #2 required cues and set up for personal hygiene and oral care. CNA #2 said she was working on the hall for Resident #2 at the time of the survey, but normally she worked in a different hall and had not noticed Resident #2 was missing a tooth. CNA #2 said if she saw a resident lost a tooth or if she was not sure if the nurse knew, she would tell her hall nurse so that they could complete an assessment. CNA #2 said she recently did a training related to oral care. (continued on next page)

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F 0791 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	CNA #3 was interviewed on 10/1/25 at 5:33 p.m. CNA #3 said she worked at the facility for the last six months and regularly worked the hallway Resident #2 lived on. CNA #3 said she could check the Kardex or the care plan for the ADL needs for each resident. CNA #3 said Resident #2 required assistance with set up and cues for oral care and personal hygiene. CNA #3 said she recently completed an education about providing oral care. CNA #3 said she had not noticed that Resident #2 was missing a tooth. CNA #3 said if she did notice a resident was missing a tooth, she would contact the nurse right away so that the nurse could follow up with that resident. The nursing home administrator (NHA) and the director of nursing (DON) were interviewed together on 10/1/25 at 5:01 p.m. The NHA and the DON said they were not aware Resident #2 was missing a tooth until the time of the survey. The DON said she did not know why no staff were aware Resident #2 lost a tooth, and she expected any CNA to inform the hall nurse for a resident if a broken or missing tooth was found and she expected any nurse to complete and document an assessment in order to ensure the resident was offered dental services if they wanted and to prevent an infection. The NHA said the facility recently completed education on providing oral care, but they planned to include new education to educate staff on communicating changes in a residents condition. III. Resident #1 A. Resident status Resident #1, age greater than 65, was admitted on [DATE]. According to the October 2025 CPO, diagnoses included Alzheimer's disease with late onset, dementia and other diseases classified elsewhere, unspecified severity and dysphasia (difficulty swallowing). The 7/24/25 MDS assessment revealed Resident #1 had short and long term memory problems. A staff assessment identified her cognition was severely impaired. According to the MDS assessment, Resident #1 was rarely to never was able to understand others or make herself understood. She was dependent on staff for all ADL, including oral care. The MDS assessment did not identify the resident had a loose or broken tooth. -However, the resident's care plan indicated the resident's teeth were in poor condition (see record review below). B. Resident #1's representative interview Resident #1's representative was interviewed on 10/1/25 at 2:37 p.m. The resident's representative said she came to the facility on 9/3/25 to visit Resident #3 and noticed that Resident #1 was missing most of a tooth. She said Resident #1's lip was drooping where the tooth had been and there was a small broken piece of her former tooth that remained in place. She said she reported the broken tooth to the facility and they placed her on antibiotics. The representative said she was concerned that no one else noticed Resident #1's broken tooth. She said the last time Resident #1 went to the dentist was three years ago. She said the facility had not offered for the resident to see the dentist. C. Record review (continued on next page)

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F 0791 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	The vision, hearing, speech and dental care plan, revised 7/31/25, identified Resident #1's teeth were in poor condition. Pertinent interventions, initiated on 7/29/25, directed staff to notify the physician of any concerns and assist the resident with appointments. The 7/15/25 long-term care quarterly evaluation documented the resident had her own teeth. According to the evaluation, her teeth were not assessed and/or there was no information. The evaluation indicated oral care was not performed on Resident #1 was because she was independent. -However the 7/24/25 MDS assessment documented to the resident was dependent with her oral care. A 9/3/25 concern/grievance card was provided by the nurse manager/assistant director of nursing (NM) on 10/1/25 at 5:58 p.m. The grievance card was created by Resident #1's representative on 9/3/25. According to the grievance card, Resident #1 had a broken tooth in the front of her mouth and the representative was not notified. The 9/3/25 nursing note documented Resident #1's representative alerted social services that Resident #1 had a cracked tooth. According to the note, staff would monitor the resident for any signs of infection or increased mouth pain. The 9/3/25 skin check note identified an exam of the resident's mouth on 9/3/25 revealed Resident #1's upper left tooth was missing and the tooth beside the missing area was red and inflamed around the base of the neighboring tooth. A 9/3/25 facility investigation was provided by the facility on 10/1/25. The investigation documented there was an unknown time frame or cause found during the investigation as to reasoning/incident surrounding the missing tooth. The representative of Resident #1 told the nursing home administrator (NHA) that she wanted to make sure that Resident #1's dental issues were not being neglected. According to the investigation, the staff had not noticed the missing tooth because there was no change in her eating or signs of pain/discomfort. The investigation indicated the resident was provided antibiotics due to her high risk for infection. The 9/5/25 nursing note documented Resident #1 returned to the facility (after her dental appointment) after her broken tooth was extracted. The extracted area of the mouth was swollen and had five out 10 pain with use of the non-verbal pain scale. A 10/1/25 email was provided by the NHA on 10/1/25 at 3:28 p.m. The email documented the list of residents who were seen in-house by the dental hygienist during the hygienist's last two visits. The review of the provided March 2025 and June 2025 resident lists identified Resident #1 was not seen by the hygienist. Review of Resident #1 electronic medical record (EMR) did not identify the resident was seen by or offered dental services prior to her 9/5/25 appointment. D. Staff interviews (continued on next page)

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F 0791 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	The social service director (SSD) and the MDS coordinator were interviewed together on 10/1/25 at 3:57 p. m. The SSD said Resident #1's representative reported Resident #1 had a missing tooth. The SSD said the representative was upset about the missing tooth and she wanted someone to look at her mouth in case there was an infection. The SSD said the NHA was made aware of the concern. The SSD said she would usually ask residents' representatives if they had any dental concerns during care conferences. The SSD said if a representative had dental concerns then a dental appointment would be scheduled. She said if a resident required outside dental services, the facility driver would schedule an appointment and assist the residents to the appointment. She said she did not know if there was a set schedule for a resident to receive dental services. She said dentist appointments and the dental hygienist exams were usually based on request. The MDS coordinator said the nurses do a quarterly head to toe check and then request a dental appointment if they saw a concern but residents should be routinely offered and seen for dental services. The MDS coordinator was interviewed a second time on 10/1/25 at 4:28 p.m. The MDS coordinator said resident representatives should always be informed of a resident change of condition. She said Resident #1 was not able to make her needs known and staff and need staff to anticipate her needs. She said Resident #1 was not able to do any of her ADLs and was dependent on staff for eating and oral care. She said the staff should be providing her with oral care at least a day and should have routine contact with her mouth. The MDS coordinator said the nurses examine residents' mouths quarterly and as needed. CNA #1 was interviewed on 10/1/25 at 5:05 p.m. C.N.A #1 said he was the resident's regular CNA. He said he did not notice she had a missing tooth until it was reported to him on or just after 9/3/25. He said it was very hard to see into her mouth. He said she never opened her mouth fully when he brushes her teeth and she would often try to bite down on the tooth brush. He said he tried to brush her teeth very gently so she does not fracture or chip a tooth. He said she frequently grinded her teeth. RN #1 was interviewed on 10/1/25 at 5:40 p.m. RN #1 said he was Resident #1's regular nurse. He said he was not aware she had a missing or broken tooth prior to 9/3/25. He said he could not determine if the resident's tooth broken was a recent break or if it had been broken for a while. He said when he reviewed her mouth after it was reported to him, it was not bleeding, swollen, or had evidence of sharp edges. He said the resident would often grind her teeth. The medical records director was interviewed on 10/1/25 at 5:59 p.m. The medical records director identified herself as the scheduling coordinator. She said she helped coordinate dental services/appointments after she received requests from the nurses or social services. She said residents were usually seen at minimum once a year for dental services. She said most residents have biannual and annual dental services for preventive care. She said SSD was responsible for tracking when a resident would need to be seen by a dental provider. She said all residents should have the option to see the dental hygienist who could come to the facility. The medical records director said she would get a copy of residents to be seen by the dental hygienist. She said she did not think Resident #1 had been on the list to be seen. (continued on next page)

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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 0791 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	The NHA, the MDS coordinator and the NM were interviewed together on 10/1/25 at 6:02 p.m. The NHA said Resident #1's representative contacted her on 9/3/25 and told her that Resident #1 was missing a tooth. The NHA said she started an investigation and could find any staff member who could tell what happened to the tooth. The NM said the review of the resident's mouth identified Resident #1's left upper front tooth was significantly broken. The NHA said she interviewed CNA #1 who told her it was hard for staff to look at her teeth because she clamped down and would not open her mouth wide. The NHA said Resident #1's representative was upset because she felt that someone should have seen that the resident's front tooth was no longer there. The NHA said Resident #1 was not seen by the dental hygienist. The NHA said part of the problem was because of staff turnover. She said the facility had three different social services directors over the last year. She said the facility also needed to improve their ancillary tracking process. She said the facility identified the concern a few weeks ago and would implement a new tracking spreadsheet for ancillary services on 10/2/25. The NHA said the new tracking system should help ensure residents were seen by dental services one to two times a year. She said there was no documentation in the resident's EMR that had been found to identify Resident #1 was offered dental services. The NHA said the resident should have been routinely assessed by the dental hygienist to help ensure dental care, reduce infection risk and risk for swallowing a broken tooth. The NHA said the resident likely swallowed the broken tooth. She said the resident would not have been able to spit out or take out a tooth that had fallen out and was in her mouth and the tooth was not located or reported to be found on the floor.