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	12/09/2025

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 0550 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Honor the resident's right to a dignified existence, self-determination, communication, and to exercise his or her rights. (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 0550 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 observations and interviews, the facility failed to ensure care for residents was provided timely and in a manner that maintained or enhanced the residents' dignity for one (#1) of three residents reviewed for dignity out of four sample residents.Specifically, the facility failed to ensure Resident #1's behavior contract was not used as a threat. Findings include:I. Facility policy and procedureThe Resident rights policy, revised February 2021, was provided by the nursing home administrator (NHA) on 10/20/25 at 1:34 p.m. It read in pertinent part, Federal and state laws guarantee certain basic rights to all residents of this facility. These rights include the resident's right to: a dignified existence; be treated with respect, kindness, and dignity; be free from abuse, neglect, misappropriation of property, and exploitation; be free from corporal punishment or involuntary seclusion, and physical or chemical restraints not required to treat the resident's symptoms; self-determination; communication with and access to people and services, both inside and outside the facility; exercise his or her rights as a resident of the facility and as a resident or citizen of the United States; be supported by the facility in exercising his or her rights; exercise his or her rights without interference, coercion, discrimination or reprisal from the facility.II. Resident #1A. Resident statusResident #1, greater than 65, was admitted on [DATE]. According to the October 2025 computerized physician's orders (CPO), diagnoses included stroke with left-sided paralysis and aphasia (difficulty with speech and language).The 7/8/25 MDS assessment revealed the resident was cognitively intact with a brief interview for mental statu s(BIMS) score of 15 out of 15. The resident was dependent on staff for bathing, toileting, footwear and lower body dressing. Resident #1 required substantial assistance with oral hygiene, personal hygiene and upper body dressing.The resident used a manual wheelchair and was able to self-propel himself for mobility. Resident #1 required substantial assistance from staff for his activities of daily living.According to the assessment, Resident #1 had no history of behaviors directed toward others. -However, a review of electronic medical record (EMR) revealed Resident #2 had verbal outbursts towards others on 4/15/25, 5/21/25 and 7/7/15.B. Resident interviewResident #1 was interviewed on 10/21/25 at 2:33 p.m. Resident #1 requested social services assistant (SSA) #1 was also present during the interview. Resident #1 said he did not recall having any recent verbal outburst or arguments during recent activities and denied having any issues with any staff or residents in the facility. Multiple times during the interview, Resident #1 said he did not want to get anyone in trouble and asked SSA #1 multiple times if he was in trouble. Resident #1 said he used to be on a behavior contract, but said he was not aware if he was currently on a behavior contract. Resident #1 then asked SSA #1 to check for him after the interview. Resident #1 said he remembered a previous family member who was forced to leave a facility for her behavior and did not want to be kicked out of the facility.C. Record reviewResident #1's comprehensive care plan, initiated 12/10/24, included a care focus to explain what behavior was unacceptable. Pertinent interventions included: anticipating care needs and providing them before the resident becomes overly stressed, discussing behaviors with Resident #1, explaining and reinforcing why the behavior was unacceptable, using a behavior contract to help guide Resident #1 with outbursts, intervening to protect the rights and safety of others, and approaching calmly to divert to a less stimulating environment.The behavior contract, dated 11/27/24, documented Resident #1 had behaviors of yelling, hitting the table with my hand, hat or drink, and demanding my own way. The contract documented if Resident #1 expressed the listed behaviors, he would be removed from the environment and placed in a calm environment until he was able to resolve the situation in a more appropriate manner. The contract listed goal dates for managing Resident #1's behavior of 11/28/24 to 12/28/24. -However, the behavior contract remained in place with no updated goal date.The progress note, dated 5/21/25 at 11:53 a. m., documented the social services director (SSD), the SSA, the floor nurse and the floor CNA met with Resident #1 after interaction with the CNA where Resident #1 cursed out the CNA. The progress note documented Resident #1 said he was upset with the CNA because he spent too long waiting for assistance off of the commode. The progress note documented the SSD checked logs and saw residents waited five minutes from the time the call light was pressed. The Progress note documented Resident #1 became aggressive, then the SSD reminded Resident #1 of his behavior contract and told Resident #1 if he had one more aggressive episode that the staff would have to look at a facility that more meets the residents needs. The progress note documented the director of nursing (DON) was aware.The progress note, dated 8/25/25 at 5:22 p.m., documented the SSD, the SSA, the assistant NHA and the activities director (AD) met with

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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. (continued on next page)

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F 0600 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 observation, record review, and interviews the facility failed to ensure that one (#2) of three residents were free from abuse out of four sample residents.Specifically, the facility failed to protect Resident #2 from verbal abuse by Resident #1 Findings include:I. Facility policy and procedureThe Abuse, Neglect, Exploitation, and Misappropriation Prevention Program policy and procedure, revised April 2021, was provided by the nursing home administrator (NHA) on 10/20/25 at 1:35 p.m. It read in pertinent part, Our residents have the right to be free from abuse. This includes but is not limited to freedom from physical abuse. Policy Interpretation and Implementation, as part of the resident abuse prevention, the administration will:-Protect our residents from abuse by anyone, including, but not necessarily limited to: facility staff, other residents, consultants, volunteers, staff from other agencies, family members, legal representatives, friends, visitors, or any other individuals.-Identify and assess all possible incidents of abuse.II. Incident of verbal abuse by Resident #1 towards Resident #2 on 8/22/25The facility investigation revealed that on 8/22/25 at 3:00 p.m. Resident #2 was observed upset during a card game with other residents. Resident #2 was observed hitting the table, making a fist towards Resident #1 and yelling at Resident #1 with profanity statements. Resident #1 became fearful of Resident #2 after the staff were unable to immediately redirect Resident #2 away from the card game.The investigation revealed facility staff immediately separated Resident #1 and Resident #2 and placed Resident #2 on frequent monitoring (every 15 minutes) for safety. The registered nurse (RN) assessed Resident #1 and Resident #2 and found no physician injuries. Resident #1 was tearful and agreed to see the facility's in-house counselor.The investigation documented Resident #1 was interviewed by the social services director (SSD). Resident #1 voiced that she was afraid of Resident #2 because of his explosive behavior. Resident #2 voiced that she was very afraid of Resident #2 because she had once had an abusive relationship and Resident #2's behavior brought up memories of the abuse. Resident #1 voiced that Resident #2 screamed, swung his arms, hit the table, and made accusatory statements about her. Resident #1 voiced that the activities staff eventually redirected Resident #2 to his wheelchair for the safety of everyone. Resident #1 told the SSD she would like to have a referral for counseling services.The investigation documented Resident #1 was interviewed by the SSD. Resident #2 voiced that Resident #1 criticized his card playing and yelled at him. Resident #2 expressed that he felt he was not good enough to play cards because he had difficulty with his vision, and women had more rights than men. Resident #2 voiced that he would stay in his room and not attend future activities, and voiced that he felt the facility tried to discharge him to another facility because the staff and residents hated him. The SSD documented that a referral to the in-house counselor had previously been sent and Resident #2 had declined counseling services. The SSD documented Resident #2 was placed on a behavior contract and educated regarding behavior expectations and ideas to reduce agitation.The investigation documented activities assistant (AA) #1 witness statement was documented at about 2:00 p.m. and revealed Resident #2 had been annoyed and accused another resident of cheating on the card game. Resident #2 was observed with increased agitation throughout the game. The AA documented she returned to her nearby office and then saw Resident #2 waving his arms and hearing him yelling at other residents. The AA documented Resident #2 said the other residents playing the card game cheated and skipped his turn. The AA documented that Resident #2 pointed, shook, and swung his fist while he explained his actions to the AA. AA #2 witness statement documented she observed Resident #2 make a fist toward Resident #1. The AA #2 documented Resident #2 was confused and upset, and AA #2 went for help from the SSD to redirect Resident #2. The 8/22/25 4:00 p. m. Resident #1 statement documented Resident #1 voiced that Resident #2 misunderstood her about the card game. Resident #1 voiced she remained afraid of Resident #2's anger, that she had nothing against Resident #2, and thought Resident #2 sometimes upset other residents.The facility investigation revealed that the altercation was witnessed by staff members and the altercation was substantiated by the facility.III. Resident #1 (victim)A. Resident statusResident #1, age greater than 65, was admitted on [DATE] and readmitted on [DATE]. According to the June 2022 computerized physician's orders (CPO), diagnoses included congestive heart disease and difficulty walking, The 7/31/25 minimum data set (MDS) assessment revealed the Resident #2 was cognitively intact with a brief interview for mental status (BIMS) score of 15 out of 15. Resident #1 had no behaviors towards others during the review period.Resident #1 required a manual wheelchair and was dependent on staff for mobility and required substantial to maximum assistance from