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	04/11/2024

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

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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 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. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 48412 Based on observations, interviews and record review, the facility failed to ensure care for residents in a manner and in an environment that maintains or enhances each resident's dignity and respect, in full recognition of his or her individuality for two (#186 and #193) of three residents reviewed for respect and dignity out of 38 sample residents. Specifically, the facility failed to: -Ensure Resident #186 had privacy when she slept in a shirt and briefs; and, -Ensure staff answered Resident #193's call light timely to prevent the resident from experiencing an incontinent episode. Findings include: I. Resident #186 A. Facility policy The Confidentiality of Information and Personal Privacy policy, revised October 2017, was provided by the nursing home administrator (NHA) on 4/11/24 at 8:27 p.m. It read in pertinent, Our facility will protect and safeguard resident confidentiality and personal privacy. The facility will strive to protect the resident's privacy regarding his or her accommodations, medical treatment and personal care. The Dignity policy, revised February 2021, was provided by the NHA on 4/11/24 at 8:27 p.m. It read in pertinent part,Each resident shall be cared for in a manner that promotes and enhances his or her sense of well-being, level of satisfaction with life and feelings of self-worth and self-esteem. Residents are treated with dignity and respect at all times. When assisting with care, residents are supported in exercising their rights. For example residents are: groomed as they wish to be groomed, encouraged to attend the activities of their choice, including religious, political, civic, recreational or social activities, encouraged to dress in clothing that they prefer, allowed to choose when to sleep, eat and conduct activities of daily living (ADLs), and, (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	provided with a dignified dining experience. Staff promote, maintain and protect resident privacy, including bodily privacy during assistance with personal care and during treatment procedures. B. Resident status Resident #186, over the age of 65, was admitted on [DATE]. According to the April 2024 computerized physician order (CPO), diagnoses included hypertensive heart and chronic kidney disease with heart failure, acute on chronic systolic (congestive) heart failure, stage three chronic kidney disease, hemiplegia and hemiparesis (paralysis on one side on the body) following a cerebral infarction (stroke) affecting the right dominant side and chronic respiratory failure. The 4/3/24 minimum data set (MDS) assessment revealed Resident #186 was cognitively intact with a brief interview for mental status (BIMS) score of 15 out of 15. Resident #186 was dependent upon staff for toileting, hygiene, showering, dressing, putting on footwear, rolling side to side and transferring in and out of the shower. C. Observations On 4/9/24 at 9:36 a.m. Resident #186 was sleeping in bed on her back with her door wide open. Her shirt was raised just below her breasts exposing her stomach. She was wearing a brief with no pants. She had a sheet hanging over her right leg. Her window blinds were open. Staff and residents were moving up and down the hallway past Resident #186's room. Staff and residents could see Resident #186 sleeping partially exposed. On 4/10/24 at 9:43 a.m. Resident #186 was sleeping in her bed on her back with her door half-way open. Her shirt was raised just below her breasts exposing her stomach. She was wearing a brief with no pants. She had a sheet pulled up to her knees. Her window blinds were open. Staff and residents were ambulating up and down the hallway past Resident #186's room. Staff and residents could see her sleeping partially exposed. D Record review Resident #186's baseline care plan did not document if the resident preferred to sleep in a shirt and briefs or if interventions were in place to ensure the resident's right to privacy was respected. E. Staff interviews The director of nursing (DON) was interviewed on 4/11/24 at 5:54 p.m. The DON said if a resident wanted to sleep in their t-shirt and underwear the staff needed to provide the resident privacy by closing their privacy curtain, bedroom door and the blinds to their window. The DON said if the resident refused to have those items closed the facility would make arrangements to accommodate their request while providing privacy. She said the facility frequently trained staff on resident rights and dignity. (continued on next page)

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F 0550 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	The activity assistant (AA) was interviewed on 4/11/24 at 6:30 p.m. She said if a resident wanted to sleep partially or completely exposed it was their right. She said if a resident wanted to sleep in limited clothing the staff should have pulled the privacy curtain or shut the door to prevent visitors and other residents from seeing the resident exposed. She said if a resident was seen exposed it could provide the resident with a lack of dignity. She said she had not seen Resident #186 sleeping exposed with her door open. She said the resident appeared hot most of the time. Registered nurse (RN) #1 was interviewed on 4/11/24 at 6:42 p.m. She said she provided the residents with dignity and respect by pulling the privacy curtain all the way around if they preferred to sleep with limited clothing on. She said she offered residents a sheet or blanket to cover up if they wanted to sleep partially or fully exposed. The NHA and the DON were interviewed together on 4/11/24 at 7:46 p.m. The NHA said if a resident wanted to sleep in the nude or in limited clothing the facility honored their wishes. She said the privacy curtain needed to be pulled around the bed or the door needed to be closed to protect the resident's privacy and dignity. She said Resident #186 had hemiplegia on the right side of her body and needed the staff's help to get dressed and undressed or to be covered up. She said she would provide privacy and dignity education to all staff to prevent the situation from occurring again. The DON said the residents had the right to sleep in what made them comfortable but staff needed to provide them privacy. The NHA, DON and executive director (ED) were interviewed together on 4/11/24 at 8:07 p.m. The ED said resident rights were reviewed in the quality assurance committee and the facility recently had an in-service on resident rights on 4/5/24. The in-service covered the residents' right to a dignified existence, self-determination, to be fully informed, to raise grievances, right to access, regarding financial affairs, privacy and rights during discharge or transfer. The NHA and the ED said staff should always respect and protect residents' right to privacy. If a resident was in bed and had limited clothes on and preferred not to have the covers pulled up the staff needed to make sure the resident was provided privacy by pulling the privacy curtain or closing their door. The DON said each resident should have a personalized plan of care that includes the residents' needs and preferences. F. Facility follow-up The NHA provided a copy of a Promoting Privacy and Dignity in Care in-service, completed with the facility's staff, on 4/11/24 at 8:27 p.m. The education included how to promote dignity and respect for the residents. The education included ways the staff could promote dignity such as ensuring drapes and doors were closed when needed. II. Resident #193 A. Resident interview (continued on next page)

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F 0550 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Resident #193 was interviewed on 4/8/24 at 11:17 a.m. She said night call lights took longer to answer on night shift. She said call lights were usually answered around 30 minutes after the light was activated. She said she waited 45 minutes to use the restroom and accidentally had a bowel movement in her bed because the staff did not respond timely. Resident #193 said it was embarrassing for her because she was able to use the bathroom but needed assistance to get out of bed. B. Resident #193's call light log from 3/25/24 to 3/31/24 Resident #193's call light logs from 3/25/24 to 3/31/24 revealed the following: On 3/25/24 at 4:31 p.m. the resident's call light was answered 21 minutes and 48 seconds after being turned on. On 3/26/24 at 12:39 p.m. the resident's call light was answered one hour, 24 minutes and 44 seconds after being turned on. On 3/26/24 at 2:13 p.m. the resident's call light was answered 25 minutes and 32 seconds after being turned on. On 3/26/24 at 9:54 p.m. the resident's call light was answered 23 minutes and 28 seconds after being turned on. On 3/27/24 at 6:53 p.m. the resident's call light was answered 30 minutes and two seconds after being turned on. On 3/27/24 at 8:34 p.m. the resident's call light was answered 40 minutes and 33 seconds after being turned on. On 3/27/24 at 10:07 p.m. the resident's call light was answered 38 minutes and 56 seconds after being turned on. On 3/28/24 at 8:32 p.m. the resident's call light was answered 50 minutes and four seconds after being turned on. On 3/29/24 at 5:57 p.m. the resident's call light was answered three hours, 17 minutes and 37 seconds after being turned on. On 3/30/24 at 4:18 a.m. the resident's call light was answered one hour, 16 minutes and 55 seconds after being turned on. -Resident #193's call light logs were requested for April 2024, however the facility provided a duplicate copy of the resident's March 2024 call light log. C. Staff interviews (continued on next page)

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F 0550 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	The staffing coordinator (SC) was interviewed on 4/11/24 at 6:52 p.m. The SC said some residents had spoken to her about concerns with call light response times at night. She said she conducted one-on-one verbal education with the staff on the night shift and reminded them to be more mindful of the call light times. She said the other issue shared with her from the residents was the agency staff were not familiar with their individual needs. The SC said she reviewed the call light logs to support the education provided. She said when there were new certified nurse aides (CNAs) the call lights tended to have a longer response time. The call lights improved once the CNAs had more experience. She said when CNAs were hired it slowed the process down again for answering call lights. She said it was a constant problem. The SC said she reminded staff to try and keep the call lights under five minutes when possible. She said the CNAs asked the nurses for assistance when needed. She said the nurses knew they needed to help sometimes with the call lights. The SC said she felt one reason for call light concerns was because some CNAs moved slower when they helped residents and some of the CNAs did not always watch for the call lights as much as they needed to. The SC said she tried to direct the staff and show the CNAs efficient ways to assist residents in a timely manner. She said she tried to assist the CNAs as much as possible when she saw concerns. The SC said a lot of the slower call light responses were when the CNAs had difficulties with time management. She said they needed to continue to learn how to prioritize their time so they efficiently and timely assisted the residents. The SC said time management with staff was the biggest issue but she was not sure if it could be fixed or if she could train staff on time management. She said she had not conducted any training and was unaware of any recent facility training for time management. The quality assurance nurse (QAN) and the NHA were interviewed on 4/11/24 at 8:07 p.m. The QAN said time management for staff was addressed in the quality assurance meeting and plans were created but were not sustained. The NHA said some of the call light response concerns were related to staff not staying for their entire shift. She said some of them disappeared or left half an hour before their shift ended. She said she identified staff were not staggering their break times to allow for enough staff to remain on the floor to answer call lights. D. Facility follow-up An in-service education regarding call lights provided by the NHA on 4/11/24 at 8:27 p.m. read: It is everyone's responsibility to answer call lights. All departments, you never know if they want water, a Kleenex or a snack. If it is care and you are not a CNA or a nurse, please let the residents know you will tell them, if necessary to go back and let the resident know they will be with them.

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F 0553 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Allow resident to participate in the development and implementation of his or her person-centered plan of care. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 50314 Based on record review and interviews, the facility failed to ensure the right to participate in the development and implementation of his or her person-centered plan of care was provided for one (#44) of two residents out of 38 sample residents. Specifically, the facility failed to notify or involve the resident and/or the appointed medical durable power of attorney (MDPOA) of care conference discussions for Resident #44. Findings include: I. Resident #44 A. Resident status Resident #44, over the age of 65, was admitted on [DATE]. According to the April 2024 computerized physician order (CPO), diagnoses included diabetes, dementia and cerebral infarction (stroke). According to the 2/5/24 minimum data set (MDS) assessment, Resident #44 had moderate cognitive impairment with a brief interview for mental status (BIMS) score of 12 out of 15. B. Record Review A Medical Durable Power of Attorney (MDPOA), signed by the resident on 4/22/21, was obtained from the nursing home administrator (NHA) on 4/11/24 at 9:48 a.m. Resident #44 had two identified agents for decision making. The 11/3/23 multidisciplinary care conference documented registered nurse (RN) #3 attended the meeting. -There was no documentation to indicate the resident or the resident's MDPOA was invited or attended. The 2/2/24 multidisciplinary care conference documented that licensed practical nurse (LPN) #4 attended the meeting and Resident #44's friend was unable to be reached by phone. -There was no documentation to indicate the resident or the resident's MDPOA was invited or attended. The social service progress notes dated 4/11/24 documented the resident's primary MDPOA was contacted (during the survey) and gave permission to contact the alternate MDPOA or another identified friend to be involved with care conferences. II. Interviews (continued on next page)

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F 0553 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Resident #44's alternate MDPOA was interviewed on 4/10/23 at 3:35 p.m. The alternate MDPOA said they were the primary contact for Resident #44's contact as the MDPOA was out of state and was often unavailable. The alternate MDPOA said they were not aware of care conferences that took place on 11/3/23 and 2/2/24. The alternate MDPOA said they would want to be notified so they could participate. The alternate MDPOA said the primary MDPOA was also not notified. The social services director (SSD) was interviewed on 4/11/24 at 11:46 a.m. The SSD said she expected the MDPOA to be involved in care conferences. The SSD said that while she spoke to the MDPOA about who could be involved in future care conferences, this did not reflect for the care conferences that took place on 11/3/23 and 2/2/24. The nursing home administrator (NHA) was interviewed on 4/11/24 at 11:51 a.m. The NHA said she expected an identified MDPOA to be involved in care conferences. The NHA said new progress note documentation detailing who should be involved in care conferences was completed on 4/11/24 (during the survey). The NHA agreed the MDPOA should have been involved in care conferences on 11/3/23 and 2/2/24.

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F 0554 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Allow residents to self-administer drugs if determined clinically appropriate. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 40467 Based on observations, record review and interviews, the facility failed to ensure the self administration of medications was clinically appropriate for two (#7 and #46) of eight residents reviewed for medication errors out of 38 sample residents. Specifically, the facility failed to implement an interdisciplinary team (IDT) approach to assess if Resident #7 and #46 were clinically safe and appropriate for self-administration of medications. Findings include: I. Professional standard According to [NAME], P.A., [NAME], A.G., et.al., Fundamentals of Nursing, 10 ed. (2020), E.[NAME], St. Louis Missouri, pp. 2016, retrieved on 4/16/24, Do not leave medications at the bedside. If you leave the medication on the bedside table, how do you know they took the medication? Someone else could come in and take or discard the medication. II. Facility Policy The Self-Administration of Medications policy, dated February 2021, was provided by the nursing home administrator (NHA) on 4/11/24 at 6:14 p.m. It documented in pertinent part, Residents deemed safe to self-administer medications will have this documented in the medical record and the individualized care plan. III. Resident group interview The resident group was interviewed on 4/10/24 at 10:03 a.m. The group consisted of five residents (#37, #16, #24, #38 and #20), including the resident council president, who were identified as interviewable by the facility and assessment. Resident #38 said the nurses left her medications in her room because the staff knew she would take her medications. She said she often self-administered her medications without staff present. Resident #20 said the night shift nurses left her bedtime medications in her room. She said she took sleeping medications and was not tired enough to take them when the nurses came by so the nurse left the medications in her room. She said the nurses also left her pain medications in her room and she self-administered her medications herself when she needed pain relief at 8:00 p.m. and 12:00 a.m. Resident #37 said if she was in the restroom when the nurse brought her medications the nurse left the pills on her counter and she self-administered her medications. Resident #16, the resident council president, said she self-administered her morning medications after breakfast without staff present. IV. Resident #7 (continued on next page)

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F 0554 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	A. Resident status Resident #7, over the age of 65, was admitted on [DATE] According to the April 2024 CPO, diagnoses included unspecified dementia, unspecified severity, with psychotic disturbance, blindness in her right and left eye, unspecified macular degeneration and anxiety disorder. The 1/13/24 MDS assessment indicated the resident's cognition was intact with a BIMS of 15 out of 15. The resident did not have behaviors of rejections of care or other related behaviors. B. Observations and resident interview Resident #7 was interviewed on 4/8/24 at 10:44 a.m. Resident #7 said she could not see well and was blind in her right eye. The resident said she put her own eye drops in her eyes. The resident pulled a small plastic bag out of her bedside dresser drawer. The bag contained two eye drop bottles, artificial tears eye drops, Prednisolone prescription eye drops and Saline nasal spray. Next to the bag in the drawer was Flonase nasal spray. The resident said she had trouble sleeping at night because of sinus problems so she put cotton tips and nasal spray in her nose herself. -At 11:03 a.m. Resident #7 retrieved an artificial tears eye drop bottle with a white cap out of the plastic bag and asked if the bottle had a red top. The resident then pulled a Prednisolone eye drop bottle out of the bag with a red top and asked if the bottle had a red top. The resident proceeded to twist off the red top of the Prednisolone eye drop bottle and place one drop of the medication in her right eye. The resident placed a drop of the artificial tears in her left eye. The resident said she could tell the color difference of the bottle caps when she held them next to each other. On 4/11/24 at 8:27 a.m. Resident #7's bottle of artificial tears was on top of her bedside dresser and the Prednisolone was in the drawer. The resident said she could not always find her eye drops because staff placed everything in the drawer and her eye drops got buried. She said staff also moved her eye drops sometimes to the other side of the room and she had difficulty finding her eye drops. C. Family interview The resident's family member was interviewed on 4/10/24 at 1:27 p.m. The family member said the resident always put her own eye drops in her eyes when she was at home. She said Resident #7 continued to administer her own eye drops at the facility. She said the resident could not always find where she last put the eye drops in her room because she could not see well at all. D. Record review The April 2024 CPO revealed the following physician's orders for Resident #7: Pred Forte Ophthalmic Suspension at 1% (Prednisolone Acetate) for one drop in right eye four times a day for ocular pain, ordered 5/29/23. Saline Nasal Spray Nasal Solution at 0.65 % to spray in both nostrils every six hours as needed for rhinitis (inflammation and swelling of the mucous membrane of the nose), ordered 6/7/23. (continued on next page)

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F 0554 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Flonase Allergy Relief Nasal Suspension to spray in each nostril in the morning for rhinitis, ordered 10/31/23. Artificial Tears Ophthalmic Solution for drops in both eyes three times a day, ordered 11/6/23. The self care and mobility care plan, revised 1/15/24, read Resident #7 had impaired mobility, related to recent falls, blindness, weakness and did not always ask for assistance. The cognition care plan, revised 4/11/24, read Resident #7 had a BIMS score of 15 out of 15 but had episodes of confusion with an expected decline in cognitive function. -Review of the care plan did not identify the resident was deemed appropriate or safe to administer her own eye drops or nasal spray. The April 2024 medication administration record (MAR) was reviewed between 4/1/24 and 4/10/24. The MAR read the following medications were administered by a nurse: -Flonase Allergy Relief Nasal Suspension spray once a day; -Artificial Tears Ophthalmic Solution eye drops three times a day; and, -Pred Forte Ophthalmic Suspension eye drops four times a day. -However, per Resident #7, she administered her own eye drops and Flonase nasal spray and kept the medications in her bedside drawer (see observations and interview above). -According to the April 2024 MAR, the Saline Nasal Spray Nasal Solution was not administered by a nurse or known to be administered between 4/1/24 and 4/10/24. E. Staff interviews The nursing home administrator (NHA) was interviewed on 4/10/24 at approximately. She said no medications should be left in a resident's room. She said residents who administered their own medication would have to be assessed for safety and capability, have a self administration order and be able to complete their own MAR. She said she did not believe there was any resident in the facility who was assessed and ordered for self administration of medications. She said it was very rare for a resident to be able to complete the MAR. Licensed practical nurse (LPN) #2 was interviewed on 4/11/24 at 10:22 a.m. LPN #2 said she did not have any residents who had self administration medication orders. She said she was frequently Resident #7's nurse. LPN #2 said the nurse was supposed to administer her eye drops and nasal spray but the resident wanted to keep the eye drops and the nasal spray in her room because Resident #7 wanted to feel more in control. LPN #2 said it was a constant battle with the resident. She said if the resident was administering her own eye drops, she probably was not administering them in a clinically appropriate way and she would probably be getting more of the eye drops than she should. (continued on next page)

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F 0554 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	LPN #2 was interviewed again on 4/11/24 at 11:38 a.m. LPN #2 said she had moved all the eye drops and the nasal spray out of Resident #7's room. She said she had contacted the resident's family member and interviewed the resident and confirmed the resident was administering the medications herself. The resident understood why the medications could not be in her room and consented to have them removed. The resident was informed the eye drops and the nasal spray were going to be locked in the nursing cart. LPN #2 said it was normal practice to lock up the spray and the eye drops in the nursing cart. She said she was aware the medications were in the resident's room but she was trying not to upset the resident if she removed them. She said she was surprised the resident was okay that the medications would be locked up. The NHA and the director of nursing (DON) were interviewed on 4/11/24 at 12:52 p.m. The NHA said Resident #7's family member was bringing the eye drops and the nasal spray to the resident but all medications should be locked up. The DON said Resident #7 wanted the medications in her room as a sense of control. The DON said the eye drops and nasal sprays needed to be secured in the medication cart. She said the resident was probably getting more of the eye drops than was ordered by the physician. 50314 V. Resident #46 A. Resident Status Resident #46, over the age of 65, was admitted on [DATE]. According to the April 2024 CPO, diagnoses included end stage renal disease, congestive heart failure, and left lower leg amputation. According to the 10/4/23 MDS assessment, Resident #46 had no cognitive impairment with a BIMS score of 15 out of 15. The resident was not identified to complete medication administration independently. B. Observations On 4/9/24 at 8:41 a.m., Resident #46 was interviewed. During the interview, the resident had a small clear medication cup with four pills in the cup. The resident swallowed the medications over several minutes during the interview, which lasted until 8:58 a.m. No staff members were present in the resident's room between 8:41 a.m. and 8:58 a.m. when the interview took place. (cross-reference F760 for significant medication errors) C. Record Review According to the April 2024 CPO, midodrine (blood pressure medication) was ordered on 10/10/2024 to be administered three times a day at 8:00 a.m., 12:00 p.m. and 8:00 p.m. The April 2024 CPO documented it was important the resident received his morning midodrine dose before attending dialysis. The April 2024 CPO did not include an order by a physician for the resident to administer their own medications. (continued on next page)

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	04/11/2024

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

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F 0554 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	The care plan obtained from the NHA on 4/11/24 at 6:11 p.m. failed to document Resident #46 had been assessed to safely self-administer his own medications. The April 2024 medication administration record (MAR) documented the resident received his 8:00 a.m. midodrine on 4/9/24. This was documented by LPN #1. -However, LPN #1 was not present in the room to confirm the resident took his medications. D. Staff interviews Licensed practical nurse (LPN) #1 was interviewed on 4/10/24 at 4:36 p.m. LPN #1 said medication orders should always be followed. LPN #1 said Resident #46 could not self-administer medications. LPN #1 said she had witnessed Resident #46 take his medications the morning of 4/9/24, however, the resident was observed swallowing medications at 8:41 a.m. without any staff members present. LPN #1 said the cup of medications the resident consumed was Resident #46's morning medications and not someone else's medications. LPN #1 then said she did not know the time Resident #46 swallowed his midodrine. The pharmacist (PH) was interviewed on 4/11/24 at 2:02 p.m. The PH said Resident #46 was not allowed to self-administer medications. The PH said it was expected that nurses witness medication administration for residents who could not self-administer medications. The director of nursing (DON) was interviewed on 4/11/24 at 5:54 p.m. The DON said medication orders should always be followed. The DON said resident #46 could not administer his own medications, and did not have a physician's order to allow self medication administration per the facility policy. The DON said medications should not be left at the bedside if the resident could not self-administer medications. The DON said she expected nursing staff to observe residents swallow medications to ensure they had been taken as part of a normal medication administration.

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	065331	A. Building B. Wing	04/11/2024

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F 0582 Level of Harm - Potential for minimal harm Residents Affected - Some	Give residents notice of Medicaid/Medicare coverage and potential liability for services not covered. 40467 Based on record review and interviews, the facility failed to inform one (#41) of three out of 38 sample residents of changes in their services covered by Medicare Part A in a timely manner. Specifically, the facility failed to: -Provide a Notice of Medicare Provider Non-Coverage (NOMNC) to Resident #41 two days prior to discharge of Medicare Part A funded services; and, -Provide the Skilled Nursing Facility-Advance Beneficiary Notice (SNF ABN) when Resident #41 continued to reside in the facility following his discharge from Medicare Part A services. Findings include: I. Facility policy and procedure The Beneficiary Notice Requirements policy, revised November 2019, was provided by the nursing home administrator (NHA) on 4/11/24 at 5:39 p.m. The purpose of the policy was to ensure proper use and completion of the beneficiary notice requirements as defined by CMS (Center for Medicare and Medicaid Services). The policy identified CMS form 10123: Notice of Medicare Non-Coverage (NOMNC) would be Utilized when Part A stay would end because the facility determined that the beneficiary no longer required daily skilled services. According to the policy, the NOMNC must be delivered at least two calendar days before Medicare coverage services and or the second to last day of service if care is not being provided daily. The form must be delivered even if the beneficiary agreed with the termination of the services. The facility must ensure that the beneficiary or representative signed and dated the NOMNC form to demonstrate the beneficiary or the representative received the notice and understood the termination decision could be disputed. The policy identified CMS form 10055: Skilled Nursing Facility Advanced Beneficiary Notice (SNF ABN) would be Utilized when Part A stay would end because the facility determined that the beneficiary no longer required daily skilled services. The beneficiary would not receive therapy or Part B services and would remain in the facility. II. Record review A. Resident #41 The medical record revealed Resident #41 was discharged from Medicare Pat A funded therapy services on 4/10/24. The resident continued to live in the facility. (continued on next page)

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F 0582 Level of Harm - Potential for minimal harm Residents Affected - Some	The beneficiary protection notice review form was provided by the facility on 4/11/24. The notice read the resident's last covered day of Medicare Part A was 4/10/24. The facility/provider initiated the discharge from Medicare Part A services when benefit days were not exhausted. The notice review form identified a NOMNC was provided to Resident #41.The notice review form did not identify the SNF ABN form was provided to the resident. -The resident was not provided notice to show Resident #41 was provided a full description of the type of Medicare part A services that were ending, given the estimated cost of services should the resident choose to pay out of pocket to continue services, and the reason why Medicare would not continue to pay for the particular service, should the resident decide to appeal the direction. The NOMNC form for Resident #41 read the effective date of coverage for his current medicare benefit services would end on 4/10/24. The form identified the resident was given and signed the notice on 4/10/24, the same day his Medicare Part A benefits would end. -Resident #41 was not given timely information about termination of Medicare part A services within the required 48 hours notification timeframe, in order to give the resident the opportunity to appeal the decision if desired. III. Staff interviews The NHA was interviewed on 4/11/24 at 7:48 p.m. The NHA said beneficiary notices should be provided to residents within 48 hours of discontinuation of Medicare Part A services. The admissions coordinator (AC) was interviewed on 4/11/24 at 7:49 p.m. The AC said she was new to her position. The beneficiary notices were reviewed with the AC. The AC said a beneficiary notice should have been provided to Resident #41 within two to three days of discharge of Medicare Part A benefits. She said her assistant, administrative assistant (ADA) was learning the beneficiary process. The AC said Resident #41 was not provided timely NOMNC because the ADA was waiting on information regarding why the resident was not going to stay on skilled nursing services. The ADA thought she had to wait on the determination before she gave the NOMNC to Resident #41. The AC said she had just started training the ADA on the SNF ABN process and would continue to train and provide oversight. The AC said she would plan to meet with the discharge planners and the interdisciplinary team (IDT) during the morning meetings to provide education on the two to three day notification and what was needed for discharge of services.

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	065331	A. Building B. Wing	04/11/2024

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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 0677 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide care and assistance to perform activities of daily living for any resident who is unable. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 50314 Based on observations, record review and interviews, the facility failed to ensure two (#6 and #52) of two residents reviewed for activities of daily living (ADL) out of 38 sample residents received appropriate treatment and services to maintain or improve his or her abilities. Specifically, the facility failed to ensure Resident #52 and Resident #6, who were dependent on staff for care, were provided showers consistently with their plan of care. Findings include: I. Professional standard According to [NAME], P.A., [NAME], A.G., et.al., Fundamentals of Nursing, 10 ed. (2020), E.[NAME], St. Louis Missouri, pp. 1794, retrieved on 4/16/24, Frequent bathing and skin care help promote overall health and wellness. Older adults may find it necessary to bathe only every two or three days, use less soap, and increase the use of skin moisturizers. II. Resident #6 A. Resident status Resident #6, over the age of 65, was admitted on [DATE]. According to the April 2024 computerized physician order (CPO), diagnoses included multiple sclerosis (MS), neuromuscular dysfunction of the bladder, and respiratory failure. According to the 2/15/24 minimum data set (MDS) assessment, Resident #6 had no cognitive impairment with a brief interview for mental status (BIMS) score of 15 out of 15. The assessment documented Resident #6 was dependent on staff assistance for bathing. B. Resident interview Resident #6 was interviewed on 4/9/24 at 11:24 a.m. Resident #6 said she required total assistance with bathing, as her MS had advanced to the point where she could not move her arms and legs anymore. Resident #6 said sometimes staff informed her that she could not get her bath if there was no bath aide or if nursing staff was busy. Resident #6 said she preferred to bathe twice a week but usually received one bath per week. C. Record review The comprehensive care plan, dated 2/7/24, documented Resident #6 required total assistance with two staff members for bathing assistance. The comprehensive care plan documented Resident #6 preferred two baths per week. (continued on next page)

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	065331	A. Building B. Wing	04/11/2024

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F 0677 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	The bathing records from 2/12/24 through 4/4/24 showed the resident received only ten showers out of 15 opportunities. Paper bathing records showed Resident #6 also received baths on 3/28/24 and 4/11/24. This represents 12 total baths given to the resident in eight weeks of time, with five baths being offered one week after the last bath completed per facility documentation. D. Staff interviews Certified nurse aide (CNA) #1 was interviewed on 4/11/22 at 11:22 a.m. CNA #1 said that Resident #6 required total assistance of up to two staff members to give her a bath. III. Resident #52 A. Resident status Resident #52, over the age of 65, was admitted on [DATE]. According to the April 2024 CPO, diagnoses included diabetes, dementia and cerebral infarction (stroke). According to the 2/12/24 MDS assessment, Resident #52's cognitive ability was intact with a score of 13 out of 15 on the brief interview for mental status (BIMS) assessment. Resident #52 required substantial or maximum assistance with bathing. B. Record review -The care plan, dated 2/13/24, failed to document Resident #52's bathing assistance needs or preferences. Electronic bathing records documented eight completed baths of 16 bathing opportunities between 2/9/24 and 4/5/24, with one bathing refusal on 4/5/24. -There was no documentation of re-offering refused bathing services Paper bathing records showed Resident #52 also received baths on 3/7/24, 3/30/24, 4/8/24 and 4/11/24. Paper bathing records documented one additional bathing refusal on 3/18/24. -There was no documentation of re-offering baths after resident refusals on 3/5/24, 3/18/24, or 4/5/24. This represents a total of 12 baths given to Resident #52 between 2/9/24 and 4/11/24, a nine week period of time. C. Staff interviews Certified nursing assistant (CNA) #1 was interviewed on 4/11/22 at 11:22 a.m. CNA #1 said that Resident #52 required extensive one person assistance with bathing. (continued on next page)

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	065331	A. Building B. Wing	04/11/2024

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F 0677 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	The director of nursing (DON) was interviewed on 4/11/24 at 5:54 p.m. The DON said all residents should be bathed twice per week while accommodating resident preferences. The DON said she was unfamiliar with how bathing was documented and recommended interviewing the staffing coordinator (SC). Bathing records were reviewed with the DON for Resident #6 and Resident #52 during the interview. The DON said not enough baths were offered to Resident #6 and Resident #52. The DON said the facility had enough staff to complete all baths and nursing staff needed to communicate and work together better to ensure all baths were completed for residents. The DON said if a resident refused a bath it should be re-offered the next day. The staffing coordinator (SC) was interviewed on 4/11/24 at 6:11 p.m. The SC provided paper bathing records. The staffing coordinator said not enough baths were offered to Resident #6 and Resident #52. The SC said if a resident refused a bath it should be re-offered the next day.

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F 0695 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Provide safe and appropriate respiratory care for a resident when needed. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 40467 Based on observations, record review and interviews, the facility failed to ensure residents received proper respiratory treatment and care for three (#37, #55 and #77) of four residents reviewed for supplemental oxygen use out of 38 sample residents. Specifically, the facility failed to: -Administer oxygen in accordance with the physician's order for Resident #55 and Resident #77; and, -Ensure Resident #37 had a physician's order for oxygen use. Findings include: I. Facility policy and procedures The Oxygen Administration policy, revised October 2010, was provided by the facility on 4/11/24. According to the policy, the purpose of the policy was to provide guidelines for safe oxygen administration. The policy read in pertinent part, Verify there is a physician order for this procedure. Review the physician's order or facility protocol for oxygen administration. Review the resident's care plan to assess any special needs of the resident. Assemble the equipment and supplies as needed. II. Resident #55 A. Resident status Resident #55, over the age of 65, was admitted on [DATE]. According to the April 2024 computerized physician orders (CPO), diagnoses included chronic and obstructive pulmonary disease, acute and chronic respiratory failure with hypoxia and paroxysmal atrial fibrillation. According to the 12/31/23 minimum data set (MDS) assessment, the resident was cognitively intact with a brief interview for mental status (BIMS) score of 15 out of 15. The resident had no behavioral symptoms or rejections of care. The assessment indicated the resident received oxygen therapy and had shortness of breath or trouble breathing with exertion and when laying flat. B. Resident observations and interview On 4/8/24 at 4:13 p.m. Resident #55 was in her room wearing a nasal cannula attached to an oxygen concentrator. The oxygen concentrator flow rate was set at 5 liters per minute (lpm). The resident said she had no concerns with her oxygen. She said weekly on Mondays she received a new nasal cannula and her oxygen flow rate was to be set at 5 lpm. The resident said 5 lpm was not a new setting. She said it had been set at 5 lpm for a while. (continued on next page)

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	065331	A. Building B. Wing	04/11/2024

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F 0695 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	On 4/9/24 at 10:31 a.m. Resident #55 wore her nasal cannula attached to her oxygen concentrator as she layed in bed. The oxygen concentrator flow rate setting remained at 5 lpm. On 4/10/24 at 1:47 p.m. the resident was in her room wearing a nasal cannula attached to her oxygen concentrator with the oxygen flow rate set at 5 lpm. She said she had not had recent breathing issues or episodes of shortness of breath. On 4/11/24 at 8:29 a.m. Resident #55 wore the nasal cannula attached to her oxygen concentrator and the oxygen flow rate was set at 5 lpm. B. Record review The respiratory care plan, initiated 7/21/23, identified Resident #55 was at respiratory risk related to chronic obstructive pulmonary disease (COPD) and chronic respiratory failure with hypoxia. The resident was dependent on continuous oxygen per nasal cannula. The respiratory care plan intervention, revised 1/1/24, directed staff to administer medications per physician's orders, provide oxygen via nasal cannula and titrate oxygen to maintain oxygen blood saturation levels above 90% and notify the physician of changes in status. -The care plan did not identify the resident adjusted her own oxygen settings (see interview below). The 1/13/24 CPO read Resident #55 had oxygen orders for 2 lpm continuously via nasal cannula. Observe skin integrity every shift at pressure points from the oxygen delivery device while in use on every shift related to COPD and chronic respiratory failure with hypoxia. -According to the oxygen order, staff needed to notify the physician if the resident required oxygen greater than 4 lpm. The 2/28/24 CPO read staff needed to check the resident's oxygen every shift for oxygen tubing kinks and safety issues. A 3/8/28 nursing note read Resident #55 was at 5 lpm with an oxygen saturation level of 95%. The 4/3/24 multidisciplinary care conference documentation read Resident #55 was on continuous oxygen related to COPD at 4 lpm and was doing well. The documentation read the resident had some shortness of breath with exertion. -The care conference documentation did not indicate the physician would be or was notified to change the resident's oxygen orders from 2 lpm continuous to 4 lpm continuous as identified in use per the multidisciplinary documentation. -The 4/3/24 documentation did not identify the resident's oxygen setting would be increased to 5 lpm as observed above. -Review of the resident's medical record did not identify the physician was notified of an increased oxygen need between the 4/8/24 through 4/11/24 survey observation period. (continued on next page)

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NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
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F 0695 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	The April 2024 treatment administration record (TAR) between 4/1/24 and 4/10/24 read the oxygen saturation levels ranged between 90% and 96% on continuous oxygen at 2 lpm via nasal cannula. The TAR indicated the resident's nurse checked and signed off on the resident's oxygen twice a day. -However, observations on 4/8/24, 4/9/24 and 4/10/24 revealed the resident's oxygen flow rate was set on 5 lpm (see observations above). III. Resident #37 A. Resident status Resident #37, over the age of 65, was admitted on [DATE]. According to the April 2024 CPO, diagnoses included unspecified dementia, unspecified severity without behavioral disturbances, generalized anxiety, interstitial lung disease with progressive fibrotic phenotype in diseases classified elsewhere, obstructive sleep apnea and chronic atrial fibrillation (an irregular and often very rapid heart rhythm). According to the 11/14/23 MDS assessment, the resident was cognitively intact with a BIMS score of 13 out of 15. The assessment did not identify the resident received oxygen therapy. B. Observations On 4/9/24 at 10:40 a.m. Resident #37 was in her room and wore a nasal cannula attached to a portable oxygen canister on the back of her wheelchair. On 4/10/24 at 4:58 p.m. Resident #37 was in the dining room. The resident wore a nasal cannula attached to her portable oxygen. On 4/11/24 at 7:48 a.m. Resident #37 wore a nasal cannula attached to her portable oxygen canister. The oxygen flow rate was set at 3 lpm. C. Record review The 7/6/23 physician's orders directed staff to obtain Resident #37's oxygen saturation levels every 24 hours as needed. -The physician's order did not identify the resident was on oxygen therapy. The cardiac care plan goal, initiated 8/17/23, read Resident #37 would maintain oxygen saturation levels above 90%. The care plan intervention, revised 2/15/24 read the resident was on oxygen PRN (as needed). The vital signs log identified Resident #37 saturation levels were monitored twice a month between 12/19/23 and 4/1/24. The vital signs log identified Resident #37 had been on oxygen via nasal cannula in December 2023, January 2024, March 2024 and April 2024. (continued on next page)

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	04/11/2024

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F 0695 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	The resident's oxygen saturation levels were 93% or above on room air and 95% or more on oxygen via nasal cannula in December 2023 and January 2024. In February 2024, the resident's saturation levels were checked on 2/1/24 and 2/17/24. Her oxygen saturation level on room air the resident was 98% on 2/1/24 and at 93% on 2/17/24. The resident's saturation levels on oxygen via nasal cannula was at 98% when her March 2024 and April 2024 oxygen saturation level was checked by staff. -The February 2024 vital signs log documented the resident had 93% or greater oxygen saturation levels when tested on room air without oxygen via nasal cannula. The March and April 2024 medication administration records for obtaining Resident #37's oxygen saturation levels as needed were left blank between 3/1/24 and 4/11/24. The April 2024 CPO did not identify the resident had physician orders for oxygen use via nasal cannula. The April 2024 treatment administration record (TAR) did not identify the resident was monitored for oxygen use. IV. Resident #77 A. Resident status Resident #77, over the age of 65, was admitted on [DATE]. According to the April 2024 CPO, diagnoses included chronic respiratory failure with hypoxia, obstructive sleep apnea and hypertensive heart disease with heart failure. According to the 2/7/24 MDS assessment, the resident's cognition was intact with a BIMS of 13 out of 15. The assessment identified the resident received oxygen therapy. B. Resident observations and interview On 4/8/24 at 4:39 p.m. Resident #77 was in his room wearing a nasal cannula attached to an oxygen concentrator. The oxygen flow rate on the concentrator was set at 3 lpm. On 4/11/24 at 10:50 a.m. Resident #77 was in his room wearing a nasal cannula attached to an oxygen canister. The oxygen flow rate was set at 3 lpm. Resident #77 said staff set his oxygen at 3 lpm and he had not had a recent change in his respiratory needs or oxygen level settings. C. Record review (continued on next page)

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	04/11/2024

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F 0695 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	The 2/1/24 physician's order directed staff to provide Resident #77 oxygen via nasal cannula every shift. -The physician's order did not specify what the resident's oxygen flow rate should be. The 2/1/24 physical therapy (PT) evaluation and plan of treatment was provided by the assistant director nursing (ADON) on 4/11/24 at 4:26 p.m. The PT evaluation read the resident needed 3 lpm of oxygen via nasal cannula. A 2/1/24 PT treatment encounter note was provided by the assistant director nursing (ADON) on 4/11/24 at 4:26 p.m. The note read Resident #77's oxygen saturation levels were 100% on 4 lpm of oxygen and 98% on 3 lpm of oxygen. According to the resident's nurse, the resident was on 2 lpm of oxygen at the hospital and the resident reported using 3 lpm of oxygen at home. The respiratory risk care plan, initiated 3/7/24, read the resident was at risk related to obstructive sleep apnea chronic respiratory failure with hypoxia, heart failure and edema. The care plan directed staff to administer medication per physician's orders, provide oxygen per nasal cannula, titrate to maintain oxygen saturation level over 90% and notify the physician of changes in status. The April 2024 TAR between 4/1/24 and 4/10/24 read the oxygen saturation levels ranged between 92% and 99% on continuous oxygen at 4 lpm via nasal cannula. The TAR indicated the resident's nurse checked and signed off on the resident's oxygen twice a day. -However, observations on 4/8/24 and 4/11/24 revealed the resident's oxygen flow rate was set on 3 lpm (see observations above). V. Staff interviews Licensed practical nurse (LPN) #2 was interviewed on 4/11/24 at 10:40 a.m. LPN #2 said the nurses and certified nursing assistants checked residents' oxygen. LPN #2 reviewed Resident #55's oxygen orders. The nurse said the resident had oxygen orders for 2 lpm. She said the resident's oxygen should not have been set at 5 lpm. She said the resident should have not been higher than 4 lpm. LPN #2 said she would notify the physician for order clarifications. LPN #2 was interviewed again on 4/11/24 at 11:38 a.m. LPN #2 said she changed Resident #55's oxygen setting to 2 lpm. LPN #2 said she thought the resident was the one who changed the oxygen setting to 5 lpm. She said she would have the resident assessed for appropriate oxygen needs and contact the physician to determine if the resident needed a higher level of oxygen than was ordered. The nursing home administrator (NHA) and the director of nursing (DON) were interviewed on 4/11/24 at 12:09 p.m. The DON said Resident #55 was changing the oxygen settings to 5 lpm. The DON said staff attempted to get a new order but the physician said her oxygen level should not be set higher. The DON said the resident said she would just continue to turn up the oxygen. (continued on next page)

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	04/11/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
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F 0695 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	The NHA said Resident #55's behavior of turning up her oxygen should have been care planned. The NHA said she would look at interventions such as educating the resident on the need for appropriate oxygen settings, offer reminders to the resident to not self adjust and provide non-pharmacological interventions when the resident felt anxious. The NHA said she would provide education for staff to monitor the resident's oxygen settings. The NHA said she would look at prevention methods so the resident could not self adjust her oxygen settings. The NHA said Resident #55 had COPD. She said if the resident received too much oxygen then she could become sick and decrease her ability to breathe. The NHA said she did not know why the resident was turning up her own oxygen. The NHA said residents' oxygen needs were assessed on admission and quarterly. She said the assessments were not documented but included respirations and review of oxygen saturation levels and oxygen orders. She said a nurse would make sure the resident was on the correct liter of oxygen to maintain a saturation level above 89%. The NHA reviewed the orders and said Resident #37 did not have an order for oxygen via nasal cannula as observed. The DON said an oxygen report identified Resident #37 used oxygen at night via CPAP (continuous positive airway pressure). The DON said the resident did not have a CPAP order. The DON said the assistant director of nursing (ADON) was in the process of identifying when and why Resident #37 was placed on oxygen via nasal cannula and provided the equipment without a physician's order. The DON said the oxygen supply company completed an audit of their oxygen equipment on 3/18/24. The DON said the supply company's audit read Resident #37 had portable oxygen equipment in place. The NHA said the resident should have had an order for the nasal cannula and documentation identifying why the resident needed the oxygen. The NHA said Resident #77's oxygen setting should not have been lower than what he had an order for. She said if Resident #77's oxygen saturation levels were consistently high, the physician should have been contacted and the order changed. The NHA said when CNAs turned the oxygen on the nurse should provide an on the spot check to make sure the oxygen was on the correct setting as oversight because oxygen was a medication. The NHA said Resident #77's saturation levels looked good so she would have his order changed. The ADON was interviewed on 4/11/24 at 4:26 p.m. The ADON said the nursing staff should check residents orders and compare the orders to the oxygen settings on every shift. The ADON said Resident #55 told staff in February 2024 she would hit them if they tried to turn her oxygen down and she would just turn the oxygen back up. The ADON said the behavior should have been care planned and staff should have been monitoring it more. The ADON said Resident #37 used to have an oxygen order but she could not find a current order for her. The ADON said she contacted the oxygen supply company and Resident #37 had been receiving oxygen via a portal nasal cannula (without an order) for the past six weeks. The ADON said Resident #77 was admitted to the facility on 2 lpm of oxygen. Then he was on 3 lpm of oxygen and saturation levels were holding steady. The ADON said the therapy notes read therapy bumped up his oxygen to 4 lpm. She said therapy could not change oxygen so a nurse must have entered the 4 lpm oxygen order on 2/1/24. (continued on next page)

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F 0695 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	-Review of provided PT notes (above) and evaluation did not identify PT felt the resident should have been on 4 lpm of oxygen. The quality assurance nurse (QAN), the NHA, the DON and the executive director (ED) were interviewed on 4/11/24 at 8:07 p.m. The QAN said oxygen management had been reviewed in the facility's quality assurance meetings. The quality assurance committee focused on ensuring residents had the right oxygen equipment assigned to them and orders matched treatment through audits. The QAN said they had identified and corrected several concerns and wrote new orders. The DON said staff turnover could have hindered sustainable changes for oxygen management concerns. The NHA said the committee needed to identify the root cause of the current oxygen concerns. VI. Facility follow up The 4/11/24 oxygen inservice education was provided by the facility on 4/11/24 (during the survey). The oxygen education was provided to 15 staff members including nursing and CNA staff. According to the education every resident that was on oxygen needed to have an order in their medical chart. Nurses and CNAs should monitor oxygen use when in the residents' rooms. CNAs should report to the nurses to ensure the oxygen was on the correct liter flow

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	065331	A. Building B. Wing	04/11/2024

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F 0759 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure medication error rates are not 5 percent or greater. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 50314 Based on observations, record review and interviews, the facility failed to ensure the medication error rate was less than five percent. Specifically, the facility had a medication error rate of 16.00%, which was four errors out of 25 opportunities for error. Findings include: I. Professional reference According to [NAME], P.A., [NAME], A.G., et.al., Fundamentals of Nursing, 10 ed. (2020), E.[NAME], St. Louis Missouri, pp. 606-607, retrieved on 4/16/24, Take appropriate actions to ensure the patient receives medication as prescribed and within the times prescribed and in the appropriate environment. Professional Standards such as nursing scope and standards of practice apply to the activity of medication administration. To prevent medication errors, follow the seven rights of medication administration consistently every time you administer medications. Many medication errors can be linked in some way to an inconsistency in adhering to these seven rights: the right medication, the right dose, the right patient, the right route, the right time, the right documentation and the right indication. II. Facility policy and procedure The April 2019 Administering Medications policy was obtained from the nursing home administrator (NHA) at 6:11 p.m. on 4/11/24. It documented that medications were to be administered within one hour of their prescribed time, unless otherwise specified such as before or after meal orders. III. Observations On 4/10/24 at 12:19 p.m. Licensed practical nurse (LPN) #3 administered insulin to Resident #193. The April 2024 computerized physician's orders (CPO) documented the resident was to receive 10 units of basal insulin before meals, and additional insulin according to the resident's blood sugar and a sliding scale. The basal and sliding scale insulin were both administered after the resident ate her lunch. -LPN #3 failed to ensure Resident #193 received insulin in accordance with the physician's order. On 4/11/24 at 8:14 a.m. registered nurse (RN) #1 administered medication to Resident #38. RN #1 reviewed the physician's orders and obtained several morning medications from the medication cart. RN #1 then administered the pills to Resident #38 in the dining hall. RN #1 said she would administer Resident #38's lidocaine patch, miralax powder, and eye drops later in the resident's room. The April 2024 medication administration record (MAR), obtained 4/11/24 at 9:02 a.m., documented the above scheduled 8:00 a.m. medications had not been given to the resident. (continued on next page)

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	065331	A. Building B. Wing	04/11/2024

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F 0759 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	-RN #1 failed to administer Resident #38's lidocaine patch, miralax powder, and eye drops within one hour according to the physician's order and facility policy. According to the April 2024 MAR, Resident #38 had a physician's order for a lidocaine patch to be administered at 8:00 a.m. for the resident's pain, Miralax was to be administered at 8:00 a.m. to alleviate constipation and two eye drops in both eyes four times a day were to be administered at 8:00 a.m. V. Staff interviews LPN #3 was interviewed on 4/10/24 at 12:53 p.m. LPN #3 said that Resident #193 was supposed to get the 10 units of basal insulin before meals. LPN #3 said Resident #193 had already eaten her meal. LPN #3 said medications ordered before meals should not be given after meals. LPN #3 said physician's orders should always be followed. RN #1 was interviewed on 4/11/24 at 9:13 a.m. RN #1 said medications should be administered within one hour of their prescribed time. RN #1 said medication orders should always be followed. The director of nursing (DON) was interviewed on 4/11/24 at 5:54 p.m. The DON said medication orders by the physician should always be followed. The DON said medications should be given within one hour of their prescribed time, unless otherwise denoted.

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	065331	A. Building B. Wing	04/11/2024

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F 0760 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure that residents are free from significant medication errors. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 50314 Based on observations, record review and interviews, the facility failed to ensure residents were free from significant medication errors for two (#46 and #193) of eight residents reviewed for medication errors out of 38 sample residents. Specifically, the facility failed to: -Administer Resident #46's midodrine (a medication used to treat low blood pressure) appropriately according to manufacturer's guidelines, and; -Administer Resident #193's insulin according to the physician's order. Findings include: I. Manufacturer's guidelines A. Midodrine hydrochloride The midodrine hydrochloride manufacturer's guidelines, dated July 9th 2020, were obtained from the National Institute of Health (NIH) Library of Medicine database on 4/16/24. It documented in pertinent part, Warnings: Supine hypertension (elevated blood pressure when lying down): The most potentially serious adverse reaction associated with midodrine therapy is marked elevation of supine arterial blood pressure (supine hypertension). Midodrine comes as a tablet to take by mouth. It is usually taken three times a day during the daytime hours (such as morning, midday, and late afternoon) with doses spaced at least 3 hours apart. B. Insulin The How to Use your Lispro Pen manufacturer's procedure guide dated March 2013 was obtained from the National Institute of Health (NIH) Library of Medicine database on 4/22/24. It documented in pertinent part, Subcutaneous Administration Humalog should be given within 15 minutes before a meal or immediately after a meal. II. Facility Policy The Administering Medications policy, dated April 2019, was obtained from the nursing home administrator (NHA) on 4/11/24 at 6:14 p.m. It documented that medications were administered in accordance with the prescriber order. (continued on next page)

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	065331	A. Building B. Wing	04/11/2024

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F 0760 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	It documented that medications were administered within one hour of their prescribed time unless otherwise specified. Residents may self-administer their own medications only if the attending physician, in conjunction with the interdisciplinary care planning team, had determined that they had the decision-making capacity to do so safely. The individual administering the medication recorded the date and time the medication was administered. The Self-Administration of Medications policy, dated February 2021, was obtained from the NHA on 4/11/24 at 6:14 p.m. It documented that residents deemed safe to self-administer medications had this documented in the medical record and the individualized care plan. III. Resident #46 A. Resident Status Resident #46, over the age of 65, was admitted on [DATE]. According to the April 2024 computerized physician order (CPO), diagnoses included end stage renal disease, congestive heart failure, and left lower leg amputation. According to the 10/4/23 minimum data set (MDS) assessment, Resident #46 had no cognitive impairment with a brief interview for mental status (BIMS) score of 15 out of 15. B. Observations On 4/9/24 at 8:41 a.m., Resident #46 was interviewed. During the interview, the resident had a small clear medication cup with four pills in the cup. The resident swallowed the medications over several minutes during the interview, which lasted until 8:58 a.m. No staff members were present in the resident's room between 8:41 a.m. and 8:58 a.m. when the interview took place. (cross-reference F554 for self-administration of medications) C. Record Review According to the April 2024 CPO, midodrine was ordered on 10/10/2023 to be administered three times a day at 8:00 a.m., 12:00 p.m., and 8:00 p.m. The April 2024 CPO documented it was important the resident received the morning midodrine dose before attending dialysis. -The April 2024 CPO did not include an order by a physician for the resident to administer their own medications. The care plan obtained from the NHA on 4/11/24 at 6:11 p.m. failed to document Resident #46 could self-administer his own medications. The April medication administration record (MAR) documented the resident received his 8:00 a.m. midodrine on 4/9/24. This was documented by LPN #1. -However, LPN #1 was not present in the room to confirm the resident took his medications. D. Staff interviews (continued on next page)

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	065331	A. Building B. Wing	04/11/2024

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F 0760 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Licensed practical nurse (LPN) #1 was interviewed on 4/10/24 at 4:36 p.m. LPN #1 said medication orders should always be followed. LPN #1 said Resident #46 could not self-administer medications. LPN #1 said she had witnessed Resident #46 take his medications the morning of 4/9/24, however, the resident was observed swallowing medications at 8:41 a.m. without any staff members present. LPN #1 said the cup of medications the resident consumed was Resident #46's morning medications and not someone else's medications. LPN #1 then said she did not know the time Resident #46 swallowed his midodrine. LPN #1 agreed that residents who were not allowed to take their own medications should be observed swallowing the medications by appropriate staff to ensure they were taken at the correct time. LPN #1 said she did not know what midodrine was, and did not research the medication or review the resident orders. The pharmacist (PH) was interviewed on 4/11/24 at 2:02 p.m. The pharmacist said that Resident #46 was not allowed to self-administer medications. The Pharmacist said giving midodrine without ascertaining the exact time it was given was incorrect medication administration. The pharmacist said that midodrine doses needed to be spaced out by at least three hours, and residents could see abnormally high or low blood pressures throughout the day if the schedule was not followed. The director of nursing (DON) was interviewed on 4/11/24 at 5:54 p.m. The DON said medication orders should always be followed. The DON said that resident #46 could not administer his own medications, and did not have a physician's order to allow self medication administration per the facility policy. The DON said bedside nurses should be familiar with the medications they were giving and should attempt to learn about medications they were unfamiliar with. The DON said she could not ascertain if Resident #46 could have been given two different doses of midodrine too close together on 4/9/24. IV. Resident #193 A. Resident Status Resident #193, age 77, was admitted on [DATE]. According to the April 2024 computerized physician order (CPO) diagnoses included type two diabetes mellitus with hyperglycemia, bipolar disorder, generalized anxiety disorder and depression. According to the 4/5/2024 minimum data set (MDS) assessment Resident #193 was cognitively intact with a brief interview for mental status (BIMS) score of 15 out of 15. The resident was not identified to self-administer medications. B. Resident observation and interview On 4/10/24 at 12:02 p.m., Resident #193 was interviewed. During the interview, a plate of remaining food appeared to be eaten on her bedside table. Resident #193 said she had eaten her entire lunch and had not yet received her insulin for the meal. On 4/10/24 at 12:19 p.m. Licensed practical nurse (LPN) #3 administered insulin to Resident #193 after the resident ate her lunch. (continued on next page)

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	065331	A. Building B. Wing	04/11/2024

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F 0760 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	-LPN #3 failed to ensure Resident #193 received insulin in accordance with the physician's order. C. Record Review The April 2024 computerized physician's orders (CPO) documented the resident was to receive 10 units of basal insulin before meals, and additional insulin according to the resident's blood sugar and a sliding scale. The basal and sliding scale insulin were both administered after the resident ate her lunch. The medication administration record (MAR) dated April 2024 documented the resident was to receive ten units of insulin before meals. D. Staff interviews LPN #3 was interviewed on 4/10/24 at 12:53 p.m. LPN #3 said that Resident #193 was supposed to get the 10 units of basal insulin before meals. LPN #3 said Resident #193 had already eaten her meal. LPN #3 said medications ordered before meals should not be given after meals. LPN #3 said physician's orders should always be followed. RN #1 was interviewed on 4/11/24 at 9:13 a.m. RN #1 said medications should be administered within one hour of their prescribed time. RN #1 said medication orders should always be followed. The director of nursing (DON) was interviewed on 4/11/24 at 5:54 p.m. The DON said medication orders by the physician should always be followed. The DON said medications should be given within one hour of their prescribed time, unless otherwise denoted. V. Post-Survey Documentation A one-on-one inservice education was received from the NHA on 4/15/24 at 2:17 p.m. It documented the DON provided education to LPN #1 which included information on midodrine as a medication, the expectation for bedside nurses to familiarize themselves with resident medications and the importance of accurate medication administration documentation. The inservice also documented that the combination of these factors was what led to the nursing staff's inability to ascertain if midodrine doses were spaced out safely and appropriately.

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	065331	A. Building B. Wing	04/11/2024

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F 0761 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Ensure drugs and biologicals used in the facility are labeled in accordance with currently accepted professional principles; and all drugs and biologicals must be stored in locked compartments, separately locked, compartments for controlled drugs. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 50314 Based on observations, record review and interviews, the facility failed to ensure all drugs and biologicals were properly labeled and stored in accordance with professional standards in one of two medication storage rooms and two of five medication storage carts. Specifically, the facility failed to: -Ensure all medications and biologicals were stored appropriately in a secure location; -Ensure medications were appropriately labeled with resident names and dates they were opened; and, -Ensure medications were not expired. Findings include: I. Professional reference According to [NAME], P.A., [NAME], A.G., et.al., Fundamentals of Nursing, 10 ed. (2020), E.[NAME], St. Louis Missouri, pp. 1976, retrieved on 4/11/24, All drugs are secured in designated areas only accessible to nurses. II. Facility Policy The February 2023 Medication, Labeling and Storage Policy was obtained from the nursing home administrator (NHA) on 4/11/24 at 5:22 p.m. It read in pertinent part, Medications and biologicals are stored in the packaging, containers or other dispensing systems in which they are received. Only the issuing pharmacy is authorized to transfer medications between containers. The nursing staff is responsible for maintaining medication storage and preparation areas in a clean, safe, and sanitary manner. Compartments containing medications and biologicals are locked when not in use, and trays or carts used to transport such items are not left unattended if open or otherwise potentially available to others. III. Manufacturer's guidelines Flovent Diskus manufacturer's guidelines were retrieved from medication cart B on 4/10/24 at 3:19 p.m. the guidelines documented in pertinent part, (continued on next page)

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	065331	A. Building B. Wing	04/11/2024

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F 0761 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Flovent Diskus should be stored inside the unopened moisture-protective foil pouch and only removed from the pouch immediately before initial use. Discard Flovent Diskus 6 (six) weeks (50-mcg (microgram) strength) or 2 (two) months (100- and 250-mcg strengths) after opening the foil pouch or when the counter reads '0' (zero) (after all blisters have been used), whichever comes first. The inhaler is not reusable. IV. Observations On 4/9/24 at approximately 3:30 p.m., a clear plastic bag containing four different pills was found on the floor of the conference room. The NHA and director of nursing (DON) were notified at 3:35 p.m and the bag of medications was given to the NHA. On 4/10/24 at 11:43 a.m., medication storage cart F was inspected and contained an opened bottle of guaifenesin that expired in March 2024. On 4/10/24 at 2:32 p.m., medication storage room [ROOM NUMBER] was inspected with the ADON and held several expired over the counter medications. -One bottle of Geri-Mox was found to be expired in November of 2023. -Two bottles of stool softener were found to be expired in September of 2023. On 4/10/24 at 3:10 p.m., medication storage cart B was inspected with RN #2 and contained incorrectly labeled medications. -A Fluticasone inhaler was observed with no date on the inhaler or the medication box to indicate when it was initially opened. -An albuterol inhaler was observed with no resident name or date on the inhaler to indicate when it was initially opened. -A Trelegy Ellipta inhaler was observed with no resident name or date opened on the containing box. -A Flovent diskus was observed with a handwritten date of 4/24/23, which indicated the medication was originally opened 11 months ago. V. Staff Interviews The NHA was interviewed on 4/9/24 at 3:38 p.m. The NHA said she did not know who the bagged medications belonged to and that it could belong to the family of a resident. The NHA said that residents, families and dietary staff occasionally ate in the conference room. The NHA said medications should not be stored in a plastic bag on the floor of the conference room. RN #2 was interviewed on 4/10/24 at 3:28 p.m RN #2 said medications should only be stored in their original packaging. RN #2 said resident inhalers should have the date the medication was opened and first accessed on the inhaler and not the box. RN #2 said medication carts were checked weekly for expired medications. (continued on next page)

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	065331	A. Building B. Wing	04/11/2024

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F 0761 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	The NHA was interviewed again on 4/11/24 at 3:23 p.m. The NHA said she had not completed her investigation into the pills found in the conference room and said she did not know who the pills belonged to. The NHA said that staff, residents, and visitors had access to use the conference room at request. The NHA said all medications should be locked up and secured. The DON was interviewed on 4/11/24 at 5:54 p.m. The DON said medications should be locked at all times, except during medication administration. The DON explained that the facility used to employ a pharmacist who would check all the medication carts but the position was not replaced when he retired. The DON said it was the nurses' responsibility to check medication carts for expired medications and that task was to be completed twice weekly. The DON said she had not identified the owner of the bag of medications found in the conference room on 4/9/24 at approximately 3:30 p.m., but she had sent calls out to all staff to attempt to identify the owner of the medications. The DON said medications should not be stored in a plastic bag on the floor of the conference room.

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	065331	A. Building B. Wing	04/11/2024

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

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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** 40467 Based on record review and interviews, the facility failed to provide routine and emergency dental services to meet the needs of each resident for one (#43) of one resident reviewed for dental services out of 38 sample residents. Specifically, the facility failed to: -Ensure a timely response to replacing Resident #43's missing dentures and identify the potential impact on her eating and swallowing due to her history of swallowing difficulties;. -Ensure Resident #42 was provided with proper oral care to identify potential mouth sores as a result of her missing bottom dentures; and, -Ensure proper communication between staff members, departments, and facility vendors regarding Resident #43's needs and/or concerns related to her missing dentures. Findings included: I. Resident status Resident #43, over the age of 65, was admitted on [DATE]. According to the April 2024 computerized physician orders (CPO), diagnoses included hypertensive heart disease with heart failure, chronic obstructive pulmonary disease (COPD), type II diabetes mellitus with unspecified diabetic retinopathy without macular edema, esophageal obstruction, dysphagia oropharyngeal and anxiety disorder. According to the 2/3/24 minimum data set (MDS) assessment, the resident was cognitively intact with a brief interview for mental status (BIMS) score of 15 out of 15. The resident had no behavioral symptoms or rejections of care. The assessment did not identify the resident had problems with her dentures or swallowing difficulties. II. Resident interview Resident #43 was interviewed on 4/9/24 at 9:15 a.m. Resident #43 said she had dental issues. She said sometime around December 2023 she was eating a baked potato when her bottom denture came out her mouth. She said the denture fell on the floor and two of the teeth broke. She said a certified nurse aide (CNA) placed the dentures by her sink. Resident #43 said when she came back to her room, the dentures were gone. She said the dentures were not put back in the denture cup where she stored them. Resident #43 said she thought someone must have thrown her lower denture away because it was broken. She said she told staff her denture was missing but was told if the dentures were put in the trash, the dentures were gone. (continued on next page)

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F 0791 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Resident #43 said she was told by the dentist that her insurance would not pay for new dentures for seven years. She said she now had sores inside of her mouth. She said she now had a hard time chewing meat. Resident #43 said some of the food was cutting her gums when she ate. Resident #43 was observed on 4/10/24 at 12:23 p.m. as she ate her lunch. She said the lunch meal was soft enough for her to chew. Resident #43 was interviewed again on 4/11/24 at 3:20 p.m. Resident #43 said her mouth had been hurting for a couple of months. She said she mentioned it to someone but did not think to ask more about it. She said the SSD met with her today (4/11/24) and was told she was working on getting her new dentures. Resident #43 said she wanted to have bottom dentures back so she could eat without pain. She said meat was tough to eat and she liked meat. She said she loved potato chips but had to quit eating them because the chips hurt her mouth. She said swallowing food had been hard without her bottom dentures because she was not able to chew her food up small enough. She said she missed eating peanut butter and jelly sandwiches which she loved but the bread would get gummed in her throat. She said the dietary aide tried to blend up the sandwiches so she could swallow them but she did not like it as a blended texture. Resident #43 said the registered dietitian (RD) noticed she was starting to have trouble swallowing a couple of months ago and she said she told the RD she was having difficulty swallowing the bread (see 12/18/23 CPO below). Resident #43 said she had difficulty swallowing in the past because she had throat surgery. III. Record review The dental, hearing, vision and speech care plan, initiated 7/24/23, read Resident #43 had natural teeth. The resident was at risk for dental issues related to a broken tooth. On 6/9/22 multiple teeth were extracted. She did not wear her bottom plate because it needed to be adjusted. Social services was to make the appointments. The care plan goal was to maintain function with dental, vision, and hearing without complication. The dysphagia care plan, initiated 7/24/23, read the resident was at a high risk for aspirations/complications related to her history of dysphagia (difficulty swallowing). The cognition care plan, revised 8/4/23, read Resident #43 had impaired cognition. She made her needs known but may miss part or the intent of the message during the conversation. She may require cues and redirection during complex and multi-step tasks. Her cognition may also impact her communication. The diabetic care plan, revised 11/6/23, documented the resident was on a mechanical soft diet. The self care and mobility care plan, revised 11/6/23, read the resident required set up assistance with meals and she required extensive assistance of one staff member for personal hygiene. (continued on next page)

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	065331	A. Building B. Wing	04/11/2024

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F 0791 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	The nutrition care plan, revised 11/24/23, read Resident #43 had a nutritional problem or potential problem related to COPD, diabetes type II and esophageal obstruction. The resident needed a therapeutic diet. The 12/18/23 CPO directed staff to provide the resident a LCS (low calorie sweetener) regular texture with a thin liquid diet. The directions on the diet order read no bread. A 1/11/24 oral hygienist note in the resident's electronic medical record (EMR) read the resident had an periodic hygiene evaluation and denture care. The note read the resident said she no longer had her lower denture. The note did not identify the resident had sores in her mouth at the time of the oral care. The note recommended to staff to have the resident soak her dentures overnight and brush them in the morning. -However, the note had just documented the resident said she no longer had her lower denture. -There was no documentation in Resident #43's EMR to indicate the facility had reviewed the 1/11/24 oral hygienist's note. The 2/2/24 dietary profile read Resident #43 was on a regular diet, had swallowing problems and had a lower denture. -However, per Resident #43, her lower denture broke and went missing in December 2023 (see resident's interview above). A 2/2/24 registered dietitian (RD) nutritional assessment read Resident #43 fed herself with set up assistance. The resident was able to make her needs known. She had natural upper (teeth) and a lower denture. The resident had no chewing difficulties reported with her current diet texture. The resident continued to have occasional swallow difficulties. She had not had weight loss. -Despite the RD documenting Resident #43 had a lower denture, per Resident #43, her lower denture broke and went missing in December 2023 (see resident's interview above). The dysphagia care plan intervention, revised 2/6/24, read swallowing precautions were recommended per her physician and the speech therapist. A 2/16/24 dental consultation note read Denture adjustment. There was no additional information on the note. The dental, hearing, vision and speech care plan intervention, revised 2/6/24, directed nursing staff to help with needs/care with dental, vision, and hearing; nursing/social services to assist with appointments; and, notify the physician if any concerns. (continued on next page)

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	065331	A. Building B. Wing	04/11/2024

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F 0791 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	The 4/11/24 nursing note read Resident #43's mouth and lower gums were assessed on 4/11/24 (during the survey) related to complaints of pain from possible mouth sores on her lower gums due to not having lower dentures. The assessment of the resident's mouth identified a small red pin sized sore to the right lower front of the gum and a small red area to the left lower gum.The note read both of the sores were just under the top canine of her top dentures. The resident said her mouth only hurt when she ate salty foods, grainy foods or meat. The physician was faxed for orders for a salt water mouth rinse twice a week and an oral/mouth assessment until her new lower dentures were in her mouth. The 4/11/24 social service note read the social service director (SSD) received a follow up call from the dental office regarding Resident #43's bottom dentures. The dental office stated the request for medicaid coverage for the replacement of the bottom dentures was denied. The SSD contacted the resident's representative. The representative said she received a letter from Medicaid regarding the denial but didn't think to let anyone know about it. The SSD was waiting for a copy of the resident's appointment and denial letter to pursue different options for bottom denture replacement for Resident #43. IV. Staff interviews The SSD was interviewed on 4/9/24 at 4:31 p.m. The SSD said Resident #43 had her teeth pulled in the past and had dentures. The SSD reviewed the resident's medical record and said the nutrition assessment on 2/2/24 read Resident #43 had both upper and lower dentures. The resident went to the dentist on 2/16/24 for a denture adjustment. The SSD said she was not aware of any concerns with her dentures and she was not notified she was missing her dentures. The SSD said she could follow up with Resident #43 and her representative. The SSD said if the resident needed her dentures then she would work on getting them for her. CNA #3 was interviewed on 4/9/24 at 4:44 p.m. CNA #3 said he routinely worked with Resident #43 but she had limited requests for him and he did not know if she had lower dentures or not or if they were missing. CNA #4 was interviewed on 4/9/24 at 5:19 p.m. CNA #4 said she had worked with Resident #43 once a week for the past three weeks. She said she was aware the resident did not have lower dentures but knew nothing more about the dentures. The SSD was interviewed on 4/10/24 at 11:54 p.m. The SSD said she contacted the dental office and was told there was a prior authorization made for her bottom dentures but she was waiting on the results of the prior authorization (see record above). The SSD said she reminded staff and residents to inform her when the residents were missing items. The SSD said when a resident was missing an item, staff should tell social services so she could start looking for the item. The SSD said she spoke to the CNAs and the resident's nurse and they did know the resident was missing her bottom denture. Resident #43 said she did not know who she told when her dentures broke and then were missing. The SSD said the resident could not give her a time frame of how long the dentures were missing. The SSD was interviewed again with the NHA and the director of nursing (DON) via phone on 4/11/24 at 11:56 a.m. The SSD said the resident told her her teeth fell out and broke and social services was not informed about it. The SSD said the resident had an appointment for the dentist scheduled. The SSD said on 1/11/24, the facility's dental hygienist wrote the resident did not have her lower dentures. (continued on next page)

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	04/11/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
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F 0791 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	The NHA said the dental hygienist visited with social services but was not sure how else the facility communicated with her. The NHA said she was not aware of the resident expressing concerns with her dentures or expressing concerns with a sore mouth when she was eating. The NHA and the DON said they would have Resident #43's mouth checked for sores and set up orders for staff to check her mouth weekly. The staff would be educated to report missing items, or concerns. The DON said she would look at the past 24 hour reports and see if anything regarding the resident's dentures was noted. The SSD said the resident had an appointment for the dentist scheduled. -During the interview, the DON said the ADON had just texted her. She said the ADON reported Resident #43 had just been assessed and she had two small mouth sores. The DON said the resident would be reviewed for a possible infection with the sores. The RD was interviewed on 4/11/24 at 3:06 p.m. The RD said no one had reported to her that the resident was missing her dentures. She said she wrote on 2/2/24 the resident had her dentures. The RD said she spoke to Resident #43 weekly in the dining room and the resident did not tell her her mouth was sore when she ate. The RD said the resident was on a regular texture diet and she was not aware she was having difficulty. The RD said if a resident was having trouble eating food she would want to know but the resident's weight was fine and some residents did fine with eating a regular diet without dentures/teeth. The SSD was interviewed again on 4/11/24 at 3:34 p.m. The SSD said if she knew about the missing dentures and the denial for the replacement, she would have immediately contacted Medicaid directly to start the appeal process and seek out grants to help pay for the bottom denture replacement. She said she would have shared with the interdisciplinary team (IDT) the loss of the dentures and asked the IDT to monitor how the resident was doing without her dentures. She said she would have asked if the resident's needs were being met while the denture replacement was pending. The SSD said the IDT would review the resident's order texture and her meal tray card to make sure the resident's dietary needs were met and address it as a main concern. The SSD said the resident told her today (4/11/24) at lunch she was having a hard time chewing the meat. The resident was then provided an alternate meal. The SSD said speech therapy was asked to evaluate her to determine if the resident needed her diet texture changed while her dentures were pending. The assistant director of nursing (ADON) was interviewed again on 4/11/24 at 4:13 p.m. The ADON said the resident's nurse told her today (4/11/24) that the resident was missing her bottom dentures. The ADON said she was told the resident was now having pain when eating salty food and was having a hard time chewing without the bottom denture. The ADON said CNAs were supposed to check and clean residents' dentures and help the residents put the dentures back in the residents' mouth. She said none of the CNAs reported a concern with Resident #43's dentures. (continued on next page)

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	065331	A. Building B. Wing	04/11/2024

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F 0791 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	The ADON said if the CNAs had been providing proper oral care for Resident #43, they would have known she was missing the dentures and had mouth pain. The ADON said the CNAs had not had a recent oral care education but she would implement an oral care inservice to instruct the staff to provide denture care before and after meals. The ADON said she did not know the dental hygienist was aware and documented the resident did not have her dentures in January 2024. The ADON said staff usually read the dental hygienist notes. She said the dental hygienist usually reported concerns to the nurse and social services.

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	065331	A. Building B. Wing	04/11/2024

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F 0805 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Ensure each resident receives and the facility provides food prepared in a form designed to meet individual needs. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 48412 Based on observations, record review and interviews the facility failed to ensure nine (#3, #1, #22, #71, #59, #14, #41, #20 and #44) of 13 residents with an order for an altered mechanical soft texture, out of 38 sample residents received food and fluids prepared in a form designed to meet their needs per physician orders. Findings include: I. Professional reference The Common Ground Between NDD and IDDSI, reviewed July 2021, retrieved from on 4/23/24:https://iddsi.org/IDDSI/media/images/CountrySpecific/UnitedStates/NDD-to-IDDSI-Implementation.pdf read in pertinent partNDD of 2002 is being replaced by the IDDSI Framework, founded in 2013. This is the only professionally recognized and supported diet framework as of October 2021. NDD level three dysphagia advanced is now IDDSI soft and bite-sized level six. The NDD description stated bite-sized, soft, moist and not sticky. However, bite-sized guidelines were larger than the typical diameter of an air way. The IDDSI name of soft and bite-sized is more descriptive of what food consistency the kitchens should produce. The Soft and Bite-sized Framework, revised January 2019, retrieved from on 4/23/24: https://iddsi.org/IDDSI/media/images/ConsumerHandoutsAdult/6_Soft_Bite_Sized_Adult_consumer_handout_30Jan2019.pdf It read in pertinent part, Level six, soft and bite-sized foods: -Soft, tender and moist, but with no thin liquid leaking or dripping; -Ability to bite off a piece of food is not required; -Ability to chew bite-sized pieces so that they are safe to swallow is required; -Bite-sized piece no bigger than one and a half centimeters by one and a half centimeters (half an inch by half an inch) in size; -Food can be mashed or broken down with pressure from a fork; and -A knife is not required to cut this food. Examples of soft and bite-sized food for adults: -Meat is cooked tender and chopped so pieces are no bigger than half an inch by half an inch lump size. If the meat cannot be served soft and tender, the meat needs to be served as minced and moist (chopped with a sauce); -Fish is cooked soft enough to break and serve pieces are no bigger than half an inch by half an inch; (continued on next page)

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	065331	A. Building B. Wing	04/11/2024

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F 0805 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	-Fruit is soft and chopped into pieces no bigger than half an inch by half an inch with any excess liquid drained. Do not use fibrous parts of the fruit; -Vegetables are steamed or boiled with the final cooked size no bigger than half an inch by half an inch. Stir-fried vegetables are too firm and are not suitable; -Cereal is served with pieces no bigger than half an inch by half an inch with their texture fully softened. Drain excess liquid before serving; -No regular bread due to a high choking risk; and -Rice requires a sauce to moisten it and hold it together. Rice should not be sticky or gluey and should not separate into individual grains when cooked and served. Food characteristics to avoid are soup with pieces of food, cereal with milk, nuts, raw vegetables, dry cakes, bread, dry cereal, steak, pineapple, candies, marshmallows, raw carrot, raw apple, popcorn, peas, grapes, chicken or salmon skin, meat with gristle, overcooked oatmeal, lettuce, cucumber, uncooked baby spinach, crisp bacon, etc. II. Facility policy The Therapeutic Diets policy, revised October 2017, provided by the executive director (ED) on 4/11/24 at 11:00 a.m. read in pertinent, Therapeutic diets are prescribed by the attending physician to support the resident's treatment and plan of care and in accordance with his or her goals and preferences. The diet will be determined in accordance with the resident's informed choices, preferences, treatment goals and wishes. Diagnosis alone will not determine whether the resident is prescribed a therapeutic diet. A therapeutic diet must be prescribed by the resident's attending physician. A diet order should match the terminology used by the food and nutrition services department. A therapeutic diet is considered a diet ordered by a physician, practitioner or dietitian as part of treatment for a disease or clinical condition, to modify specific nutrients in the diet, or alter the texture of a diet. If a mechanically altered diet is ordered the provider will specify the texture modification. Snacks will be compatible with the therapeutic diet. III. Resident #3 A. Resident status Resident #3, age 88, was admitted on [DATE]. According to the April 2024 computerized physician orders (CPO), diagnoses included chronic obstructive pulmonary disease (COPD), Alzheimer's disease, dementia, personal history of other diseases of the digestive system, muscle weakness and dysphagia oropharyngeal phase (difficulty swallowing). The 2/29/24 minimum data set (MDS) assessment revealed Resident #3 had moderate cognitive impairment with a brief interview for mental status (BIMS) score of 11 out of 15. Resident #3 required a mechanically altered diet. B. Record review (continued on next page)

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	04/11/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
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F 0805 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	The physician orders, care plan and meal ticket revealed Resident #3 was on a mechanical soft diet with thin liquids. The resident was allowed to have potato chips. Resident #3's meal ticket documented the resident was on a low-concentrated sweets diet with a mechanical soft texture and thin liquids. C. Observations On 4/10/24 at 6:08 p.m. Resident #3 was served a slice of frosted cake The cake was dry and crumbly. IV. Resident #1 A. Resident status Resident #1, under the age of 65, was admitted on [DATE]. According to the April 2024 CPO, diagnoses included acute respiratory failure, multiple sclerosis (chronic disease of the central nervous system), muscle wasting and atrophy, muscle spasms and dysphagia oropharyngeal phase. The 2/19/24 MDS assessment revealed Resident #1 had moderate cognitive impairments with a BIMS score of 10 out of 15. Resident #1 required a mechanically altered diet. B. Record review The physician orders, care plan and meal ticket revealed Resident #1 was on a mechanical soft diet with thin liquids. C. Observations On 4/10/24 at 5:02 p.m. Resident #1 was served a plate that contained shrimp, spaghetti noodles, tater tots and a piece of frosted spice cake. The spaghetti noodles and cake were served at a regular texture and not altered to mechanical soft. Dietary aide (DA) #2 said the plate was correct for a mechanical soft diet. DA #3 said he was unsure if the noodles needed to be cut up or could go out whole. The plate was prevented from leaving the kitchen until it was cut into one-inch pieces and safe for the resident to eat. DA #3 cut the noodles into one inch pieces. The cake remained regular texture and was not cut into pieces. DA #3 said the cake did not need to be cut up. V. Resident #22 A. Resident status (continued on next page)

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	065331	A. Building B. Wing	04/11/2024

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F 0805 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Resident #22, age 85, was admitted on [DATE]. According to the April 2024 CPO, diagnoses included hemiplegia and hemiparesis (weakness on one side of the body) following a cerebral infarction (stroke) affecting the left nondominant side, facial weakness following a cerebral infarction, dysphagia, dysarthria (difficulty speaking), Alzheimer's disease and dementia. The 3/11/24 MDS assessment revealed Resident #22 had severe cognitive impairment with a BIMS score of five out of 15. The MDS indicated Resident #22 held food in her mouth or cheeks or had residual food in her mouth after meals. Resident #22 complained of having difficulty or pain when swallowing. The resident was on a mechanically altered diet. B. Record review The physician orders, care plan and meal ticket revealed Resident #22 was on a mechanical soft diet with thin liquids. C. Observations On 4/10/24 at 5:03 p.m., Resident #22 was served an egg salad sandwich on a croissant with a raw slice of lettuce and tomato. At 5:07 p.m., the executive director (ED) entered the kitchen and spoke with DA #3 and DA #2 about sending out the correct texture for mechanical soft orders. -However, Resident #22 was still served a raw slice of lettuce and tomato. VI. Resident #71 A. Resident status Resident #71, over the age of 65, was admitted on [DATE]. According to the April 2024 CPO, diagnoses included hemiplegia and hemiparesis following a cerebral infarction affecting the left nondominant side, dysphagia, muscle weakness, weakness and vascular dementia moderate with agitation. The 3/21/24 MDS assessment revealed Resident #71 had mild cognitive impairment with a BIMS score of 11 out of 15. Resident #71 required a mechanically altered diet. B. Record review The physician orders, care plan and meal ticket revealed Resident #71 was on a mechanical soft diet with thin liquids. C. Observations On 4/10/24 at 5:59 p.m., Resident #71 was served a plate that had mechanical soft shrimp, spaghetti noodles and tater tots. Resident #72 received a side of sliced lettuce and tomatoes. VII. Resident #59 (continued on next page)

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	065331	A. Building B. Wing	04/11/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
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F 0805 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	A. Resident status Resident #59, age 90, was admitted on [DATE]. According to the April 2024 CPO, diagnoses included COPD, chronic stage four kidney disease, hypertensive heart and chronic kidney disease with heart failure and chronic respiratory failure with hypoxia (not enough oxygen). The 3/22/24 MDS assessment revealed Resident #59 had moderate cognitive impairment with a BIMS score of 12 out of 15. Resident #59 required a mechanically altered diet. B. Record review The physician orders, care plan and meal ticket revealed Resident #59 was on a mechanical soft diet with thin liquids. C. Observations On 4/10/24 at 6:16 p.m., Resident #59 was served a slice of frosted cake that was dry and crumbly. VII. Resident #14 A. Resident status Resident #14, over the age of 65, was admitted on [DATE]. According to the April 2024 CPO, diagnoses included chronic respiratory failure, hypertensive heart disease with heart failure, chronic diastolic (congestive) heart failure, weakness and other fatigue. The 1/5/24 MDS assessment revealed Resident #14 was cognitively intact with a BIMS score of 15 out of 15. Resident #14 required a mechanically altered diet which required a change in the food's texture. B. Record review The physician orders, care plan and meal ticket revealed Resident #14 was on a mechanical soft diet with thin liquids. C. Observations On 4/10/24 at 5:24 p.m., an egg salad sandwich on a croissant with raw lettuce and tomato was plated for Resident #14. IX. Resident #41 A. Resident status Resident #41, under the age of 65, was admitted on [DATE]. According to the April 2024 CPO, diagnoses included hemiplegia (paralysis of one side of the body) affecting the left nondominant side, acute kidney failure, COPD and weakness. (continued on next page)

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	04/11/2024

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

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F 0805 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	The 3/6/24 MDS assessment revealed Resident #41 had severe cognitive impairment with a BIMS score of six out of 15. Resident #41 required a mechanically altered diet. B. Record review Resident #41's meal ticket documented the resident needed a regular diet with a mechanical soft texture and thin liquids. C. Observations On 4/10/24 at 6:21 p.m., Resident #41 was served a slice of frosted cake that was dry and crumbly. X. Resident #20 A. Resident status Resident #20, age 89, was admitted on [DATE]. According to the April 2024 CPO, diagnoses included chronic kidney disease, disorientation, unspecified sequelae of other cerebrovascular disease (a group of conditions that affect blood flow to the brain) and unspecified coughing. The 2/26/24 MDS assessment revealed Resident #20 was cognitively intact with a BIMS score of 15 out of 15. Resident #20 required a mechanically altered diet. B. Record review The physician orders, care plan and meal ticket revealed Resident #20 was on a mechanical soft diet with thin liquids. C. Observations On 4/10/24 at 5:18 p.m., Resident #20 requested a salad. DA #3 served a salad with all raw vegetables to the resident. XI. Resident #44 A. Resident status Resident #44, age 84, was admitted on [DATE]. According to the April 2024 CPO, diagnoses included atherosclerotic heart disease of native coronary artery (plaque build-up in the arteries), personal history of transient ischemic attack (a stroke that only lasts a few minutes) and cerebral infarction without residual deficits and weakness. The 2/5/24 MDS assessment revealed Resident #44 had moderate cognitive impairments with a BIMS score of 12 out of 15. Resident #44 required a mechanically altered diet. B. Record review (continued on next page)

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	04/11/2024

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F 0805 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Resident #44 did not have a physician's order documenting she needed a modified diet texture. A physician's order was entered on 4/11/24 (during the survey) which documented Resident #44 was able to safely eat danishes and cinnamon rolls and could have those food items as a regular texture. However, Resident #44's meal ticket documented the resident was on a regular diet with a mechanical soft texture and thin liquids. C. Observations On 4/10/24 at 5:54 p.m., Resident #44 was served a slice of frosted cake that was dry and crumbly. XII. Staff interviews The speech therapist (ST) was interviewed on 4/11/24 at 8:28 a.m. The ST said the facility followed the National Dysphagia Diet for modified diet textures and planned to switch to the international dysphagia diet standardization initiative soon. The ST said the facility had residents on pureed, level three dysphagia advanced (mechanical soft) and regular diet textures. The ST said mechanical soft diets required food that was mashable with a fork without any effort. She said the residents who were on a mechanical soft diet could have bread that was soft and without crust. She said the cooks needed to add sauce to the foods in order to moisten them. She said she evaluated every resident when they were admitted to the facility to ensure the diet they were on previously was correct or if it needed to be changed. The ST said the resident's diet orders which were included on their meal tickets needed to be followed for the residents'safety. She said if a resident had a special request to eat a certain food item that was a regular texture she evaluated the resident to ensure they ate it safely and a physician's order for the appropriate diet texture was entered into the resident's electronic medical record (EMR). She said she was going to provide the dietary staff with education on 4/18/24 for mechanical soft textures and foods that were safe for the residents to eat to ensure the staff were aware of the diet textures. Certified nurse aide (CNA) #2 was interviewed on 4/11/24 at 9:52 a.m. CNA #2 said she assisted residents at meals if they needed help eating. She said mechanical soft meats needed to be ground. She said the residents could not have berries. She said the residents on a mechanically altered diet were limited on fruit options because it was too hard. She said she was unsure if the residents could have bread on a mechanical soft diet. CNA #2 said when she was assisting residents she cut everything into bite-sized pieces. She said if she saw the resident's texture was incorrect she sent it back to the kitchen to be corrected. She said she had not received training at the facility about modified diet textures. Nurse aide (NA) #1 was interviewed on 4/11/24 at 9:57 a.m. She said she could not serve residents until she was certified, but she said mechanical soft foods needed to be in bite-sized pieces. She said she had not received training at the facility on modified diet textures but recently learned about it in some of her CNA classes. She said if the texture was incorrect for the resident she would send it back to the kitchen to be fixed. (continued on next page)

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	065331	A. Building B. Wing	04/11/2024

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F 0805 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Dietary aide (DA) #5 was interviewed on 4/11/24 at 10:01 a.m. DA #5 said she took the residents'meal and drink orders. She said residents on a mechanical soft diet received bread without crust. She said the residents could have whole french fries if they were fresh and not extremely crispy. She said meats needed to be ground. She said she had received training recently on modified diet textures. Registered nurse (RN) #1 was interviewed on 4/11/24 at 10:06 a.m. RN #1 said residents who were prescribed a mechanical soft diet needed to receive ground meats. She said mechanical soft salads needed to be chopped up in tiny pieces. She said if a resident was served a plate that did not look like it was the correct texture she would return it to the kitchen. She said it was important to follow the correct physician ordered texture modification for the residents'safety. She said food needed to be in small pieces for residents on mechanical soft diets. DA #3 was interviewed on 4/11/24 at 10:20 a.m. DA #3 said he worked as a DA and in the central supply office. He said he worked in the kitchen on 4/10/24. He said there had been some turnover in dietary management over the last few months which had led to some issues in the kitchen. He said the dietary department currently did not have a manager. He said he had not received completed training on how to be a cook or modified diet textures but knew how to make pureed meals and some mechanical soft meals. DA #3 said he tried his best to serve the residents correctly. The registered dietitian (RD) and executive director (ED) were interviewed together on 4/11/24 at 10:28 a.m. The RD said food needed to be mashable with a fork for a mechanical soft diet. She said the bread needed to have the crust cut off. The RD said if a resident wanted to eat something that was not mechanical soft, the ST evaluated the resident to ensure they ate the food item safely. The RD said when the speech evaluation was completed a physician's order was entered into the resident's EMR indicating the resident could have the certain food item. She said there was a resident who loved potato chips who was assessed by the ST and since the resident ate the chips safely, her order was updated. She said it was important to ensure all food items on each resident's tray were the correct texture before leaving the kitchen. The ED said she was putting together training for all staff, especially the dietary staff, for the week of 4/15/24 to go over modified diet textures. She said she wanted the staff to know what each resident needed for their meals and for the residents to receive the correct modified diet so they would not choke on their food. The RD said she was not up-to-date on what mechanical soft diets could and could not receive but she was working with the ST to get everyone on the same page. XIII. Facility follow-up A sign was posted in the kitchen on 4/11/24 (during the survey) by the ST which documented what residents could and could not eat on a mechanical soft diet. A copy of the sign was provided by the ED on 4/11/24 at 7:45 p.m. It read in pertinent part, Mechanical soft texture must be soft or moist and mashable with a fork. Sandwiches need the crust cut off and to be cut into one-inch pieces mixed with a moist sandwich ingredient. All breads must be soft and moist and cut into one-inch pieces. No nuts, seeds, hard candy, raw fruits or vegetables, crunchy fruits or vegetables. All food must be cut up in one-inch pieces.

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	065331	A. Building B. Wing	04/11/2024

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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 0812 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	Procure food from sources approved or considered satisfactory and store, prepare, distribute and serve food in accordance with professional standards. 48412 Based on observations, record review and interviews, the facility failed to store, prepare, distribute and serve food in a sanitary manner in the main kitchen. Specifically, the facility failed to ensure: -Appropriate hand washing and glove usage in the main kitchen; -The cook wore a beard net while serving food; -Food was reheated appropriately; and, -Hand hygiene was offered to residents during meal times. Findings include: I. Staff hand hygiene A. Professional reference According to The Colorado Department of Public Health and Environment (2024) The Colorado Retail and Food Establishment Rules and Regulations retrieved on 4/18/24 from https://drive.google.com/file/d/1kEtv4f6YciFXXzLEu6amUc9Anu9uWGYn/view, Food employees shall clean their hands and exposed portions of their arms immediately before engaging in food preparation including working with exposed food, clean equipment and utensils, and unwrapped single-service and single-use articles and: after touching bare human body parts other than clean hands and clean, exposed portions of arms; after using the toilet room; after coughing, sneezing, using a handkerchief or disposable tissue; after handling soiled equipment or utensils; before donning gloves to initiate a task that involves working with food; and, after engaging in other activities that contaminate the hands. If used, single-use gloves shall be used for only one task such as working with ready-to-eat food or with raw animal food, used for no other purpose, and discarded when damaged or soiled, or when interruptions occur in the operation. B. Facility policy and procedure (continued on next page)

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	04/11/2024

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F 0812 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	The Preventing Foodborne Illness- Employee Hygiene and Sanitary Practices policy, revised November 2022, was provided by the executive director (ED) on 4/11/24 at 11:40 a.m. It read in pertinent: Food and nutrition services employees follow appropriate hygiene and sanitary procedures to prevent the spread of foodborne illness. All employees who handle, prepare or serve food are trained in the practices of safe food handling and preventing foodborne illness. Employees will demonstrate knowledge and competency in these practices prior to working with food or serving food to residents. Employees must wash their hands: after personal bodily functions (toileting, blowing or wiping nose, coughing or sneezing); whenever re-entering the kitchen; and, after engaging in other activities that contaminate the hands. Contact between food and ungloved hands is prohibited. Gloves are considered single-use items and must be discarded after completing the task for which they are used. The use of disposable gloves does not substitute for proper hand washing. Gloves are worn when directly touching ready-to-eat foods. Food service employees are trained in the proper use of utensils such as tongs, gloves, deli paper and spatulas as tools to prevent foodborne illness. The Handwashing or Hand Hygiene policy, revised August 2019, provided by the ED on 4/11/24 at 11:40 a.m. It read in pertinent, This facility considers hand hygiene the primary means to prevent the spread of infections. All personnel shall follow the handwashing or hand hygiene procedures to help prevent the spread of infections to other personnel, residents and visitors. Hand hygiene is the final step after removing and disposing of personal protective equipment. The use of gloves does not replace hand washing or hand hygiene. Integration of glove use along with routine hand hygiene is recognized as best practice for preventing healthcare-associated infections. Perform hand hygiene before applying non-sterile gloves and perform hand hygiene when removing non-sterile gloves. C. Observations During a continuous observation on 4/10/24, beginning at 4:40 p.m. and ending at 6:20 p.m., the following was observed: -At 4:44 p.m. dietary aide (DA) #2 prepared the meal trays going on the meal cart. He wiped his nose on the back of his glove. DA #2 did not wash his hands or change his gloves prior to picking up the resident meal tickets and sorting them. -At 4:47 p.m. DA #3 had a pair of gloves on both hands as he sorted out meal tickets that were collected from the resident's rooms. He used the same gloves to touch clean dishes and serving utensils. Without changing gloves or performing hand hygiene, he grabbed a handful of tater-tots with the gloves and placed them on a resident's plate. -At 5:59 p.m. DA #3 picked up the meal tickets with the same gloved hands and sorted them again. Without changing gloves or performing hand hygiene, he grabbed a clean plate and used his gloved hand to grab a handful of tater-tots and put them on a plate to be served to a resident. -At 6:05 p.m. DA #2 stuck his head outside of the kitchen door and sneezed. He wiped his nose on the back of his glove again and continued wiping his nose on the back of his arm from his wrist to his elbow. DA #2 walked to the handwashing sink in the kitchen and grabbed a paper towel. He used his gloved hands to wipe his nose with the paper towel. He disposed of the used paper towel and continued serving resident meals without changing his gloves or performing hand hygiene. (continued on next page)

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	065331	A. Building B. Wing	04/11/2024

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F 0812 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	-At 6:11 p.m. DA #2 used the same gloved hand to scratch his upper inner thigh and continued preparing trays for residents. -At 6:20 p.m. DA #3 changed one of his gloves but kept the other one on and did not wash his hands. D. Staff interviews The ED and registered dietitian (RD) were interviewed together on 4/11/24 at 10:28 p.m. The RD said the dietary staff were all new and still learning their duties and what leadership expected from them. The ED said DA #3 and DA #2 should have washed their hands and changed their gloves more often. The ED said she would provide education to the dietary staff regarding hand hygiene at the end of the survey. The RD said the gloves needed to be changed after touching something that was not for the current task. She said when DA #3 grabbed the meal tickets brought from the residents'rooms, he should have changed his gloves. She said if someone picked up something off of the floor they needed to change their gloves. The ED said any time staff changed their gloves they needed to wash their hands with soap and water in the kitchen. She said if they were not in the kitchen, staff could also use hand sanitizer between glove changes. II. Hair restraints A. Professional reference According to the Colorado Department of Public Health and Environment (2024) The Colorado Retail and Food Establishment Rules and Regulations retrieved on 4/18/24 from https://drive.google.com/file/d/1kEtv4f6YciFXXzLEu6amUc9Anu9uWGYn/view Food employees shall wear hair restraints such as hats, hair coverings or nets, beard restraints and clothing that covers body hair, that are designed and worn to effectively keep their hair from contacting exposed food, clean equipment, utensils, linens and unwrapped single-service and single-use articles. B. Facility policy and procedure The Preventing Foodborne Illness- Employee Hygiene and Sanitary Practices policy, revised November 2022, was provided by the ED on 4/11/24 at 11:40 a.m. It read in pertinent part, Hair nets or caps and beard restraints are worn when cooking, preparing or assembling food to keep hair from contacting exposed food, clean equipment, utensils and linens. C. Observations (continued on next page)

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F 0812 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	During a continuous observation on 4/10/24, beginning at 4:40 p.m. and ending at 4:51 p.m., the following was observed: -At 4:40 p.m. DA #3 was preparing meals for the short-term rehab side of the building without a beard net on. -At 4:52 p.m. the ED asked DA #3 to put on a beard net since he was cooking and plating food. D. Staff interviews The ED was interviewed on 4/11/24 at 10:28 p.m. The ED said she told DA #3 to put on a beard net because he needed to prevent potential contamination of the meal from hair. DA #3 was interviewed on 4/11/24 at 10:20 a.m. DA #3 said he was not used to wearing a beard net because he usually served the meals in the dining room and did not work as the cook. He said when the ED told him to put on a beard net he complied. III. Reheating of foods A. Professional reference The Colorado Department of Public Health and Environment (2024) The Colorado Retail and Food Establishment Rules and Regulations retrieved on 4/18/24 from https://drive.google.com/file/d/1kEtv4f6YciFXXzLEu6amUc9Anu9uWGYn/view, Ready-to-eat time or temperature control for safety food that has been commercially processed and packaged in a food processing plant shall be heated to a temperature of at least 135 degrees Fahrenheit (F). B. Observations During a continuous observation on 4/11/24, beginning at 4:40 p.m. and ending at 6:48 p.m., the following was observed: -At 5:31 p.m. DA #4 microwaved a bowl of chicken noodle soup for three minutes. When the chicken noodle soup was done, DA #4 immediately served the bowl of steaming chicken noodle soup to a resident. DA #4 did not take the temperature of the soup prior to serving it to a resident. While the chicken noodle soup was in the microwave, DA #5 placed two hot dogs on the flat top to cook. -At 5:36 p.m. DA #5 removed the hot dogs from the flat top and immediately served them to a resident without taking the temperature. -At 5:39 p.m. DA #4 put another bowl of soup in the microwave for three minutes. He took the soup out of the microwave. The soup was steaming and he immediately served it to a resident without taking the temperature of the soup. C. Staff interviews (continued on next page)

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F 0812 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	The ED and RD were interviewed together on 4/11/24 at 10:28 p.m. The ED said the temperature of all food items needed to be taken prior to serving the food to residents. The ED said DA #4 started working in the kitchen less than a week ago and she was going to provide him more education. IV. Resident hand hygiene before meals A. Facility policy and procedure The Handwashing or Hand Hygiene policy, revised August 2019, was provided by the ED on 4/11/24 at 11:40 a.m. It read in pertinent, This facility considers hand hygiene the primary means to prevent the spread of infections. All personnel shall follow the handwashing or hand hygiene procedures to help prevent the spread of infections to other personnel, residents and visitors. B. Observations During a continuous observation on 4/8/24, beginning at 12:10 p.m. and ending at 12:32 p.m., the following was observed in the rehabilitation building's dining room: -At 12:10 p.m. four residents were observed in the dining room of the short-term rehab buildings. The staff did not offer residents hand hygiene before the residents were served their meals. -At 12:27 p.m. a resident self-propelled his wheelchair into the dining room placing his hands on the wheels. He went to his table and was served his plate. The resident used his hands to eat a dinner roll. The staff did not offer or encourage the resident to clean his hands before eating his meal. -At 12:32 p.m. a resident walked into the dining room carrying his portable oxygen tank and sat at a table where his lunch was placed. The staff did not offer or encourage the resident to perform hand hygiene. He sat his oxygen tank on the ground and started eating his meal. The resident used his hands to eat a dinner roll. During a continuous observation on 4/10/24, beginning at 5:08 p.m. and ended at 6:08 p.m. the following was observed: -At 5:08 p.m. Resident #20 self-propelled her wheelchair into the dining room toward her table. She used her hands to touch the wheels of her wheelchair and to adjust her positioning at the table. The resident was not offered or encouraged to perform hand hygiene after she touched the wheels of her wheelchair and before she ate her meal. Resident #20 used her hands to eat a dinner roll. -At 5:09 p.m. Resident #73 self-propelled her wheelchair into the dining room with her feet as she held her baby doll. She sat at a table in front of a bag of opened potato chips. The resident was not offered or provided hand hygiene before she began to eat the chips with her hands. -At 5:13 p.m. Resident #73 left the dining room table, touched her tablemate's wheelchair handle with her left hand, propelled her wheelchair towards the nurse in the dining room and held his hand with her left hand. The resident was not offered hand hygiene. (continued on next page)

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	065331	A. Building B. Wing	04/11/2024

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F 0812 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	-At 5:18 p.m. Resident #73 returned to her dining table and used her right hand to touch the shoulder of the restorative aide (RA) sitting next to her. The resident was not offered hygiene. -At 5:19 p.m. Resident #73 was served her meal. She proceeded to retrieve her utensils from her rolled napkin by placing her fingers on the eating surface of the utensils. The resident then used the spoon to eat her pudding. C. Resident interviews Resident #20 and Resident #38 were interviewed on 4/10/24 at 5:27 p.m. in the main dining room. Resident #20 said the wipes on the table were for cleaning your hands. Resident #38 said the bottle of hand sanitizer was used to clean their hands too but the staff just added the bottles of hand sanitizer to the tables on 4/10/24 (during the survey). -However, neither resident was observed sanitizing their hands nor was staff observed encouraging the residents to utilize the hand sanitizer or wipes. D. Resident group interview The resident group was interviewed on 4/10/24 at 10:03 a.m. The group consisted of five residents (#37, #16, #24, #38 and #20), including the resident council president, who were identified as interviewable by the facility and assessment. Resident #24 said there were blue packs of wipes on the dining room tables for the residents to wipe their hands before they eat. She said the staff did not offer hand hygiene to the residents before any meal. She said the blue packs of wipes were the same wipes she had in her bathroom to clean her peri-area with. Resident #16 said she only ate meals in her room and was not offered hand hygiene. She said she did not know wipes were available before meals. Resident #38 said the blue wipes were left on the tables in the dining room as long as the facility did not run out of them, which happened often. E. Staff interviews Registered nurse (RN) #1 was interviewed on 4/11/24 at 6:42 p.m. She said she did not offer the residents hand hygiene when delivering the meal trays. The NHA and DON were interviewed together on 4/11/24 at 7:46 p.m. The DON said residents needed to be offered hand hygiene before their meals. V. Facility follow-up (continued on next page)

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F 0812 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	The ED provided the facility's dietary training plan on 4/15/24 at 5:01 p.m. The training was scheduled for 4/18/24 at 9:30 a.m. It consisted of hands-on training for the dietary staff. The training included hand hygiene, glove usage and kitchen sanitation. Additional training was sent out to all facility staff in the facility's electronic training system to cover all content that was covered in the in-person training. After the training was completed the staff were required to complete a post-training exam.