STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	065399	A. Building B. Wing	07/24/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Rio Grande Rehabilitation and Healthcare Center	39 Calle Miller LA Jara, CO 81140

For information on the nursing home's plan to correct this deficiency, please contact the nursing home or the state survey agency.

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0603 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Protect each resident from separation (from other residents, his/her room, or confinement to his/her room). (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

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	065399	A. Building B. Wing	07/24/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Rio Grande Rehabilitation and Healthcare Center	39 Calle Miller LA Jara, CO 81140

For information on the nursing home's plan to correct this deficiency, please contact the nursing home or the state survey agency.

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0603 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on record review and interviews, the facility failed to ensure the resident had the right to be free from involuntary seclusion not required to treat the resident's medical symptoms for one (#2) of one out of seven sample residents.Specifically, the facility failed to ensure Resident #2 was not told to go to her room or taken to her room as punishment for her behaviors. Findings include: I. Facility policy and procedureThe Resident Rights policy, revised December 2021, was provided by the nursing home administrator (NHA) on 7/24/2 at 3:20 p. m. It read in pertinent part, Federal and state laws guarantee certain rights to all residents of this facility. These rights include the resident's right to a dignified existence, to be treated with respect, kindness, and dignity, to be free from involuntary seclusion, to be supported by the facility in exercising resident rights, and to have equal access to quality care.II. Resident #2A. Resident statusResident #2, age greater than 65, was admitted on [DATE]. According to the July 2025 computerized physician's order (CPO), diagnoses included unspecified dementia with unspecified severity without behavioral disturbance and other specified depressive episodes. The 4/6/25 minimum data set (MDS) assessment revealed Resident #2 had short-term and long-term memory problems per staff assessment. Resident #2 required supervision from staff for activities of daily living (ADLs).The MDS assessment indicated the resident had no behavioral symptoms. B. Resident interviewResident #2 was interviewed on 7/24/25 at 1:22 p.m. Resident #2 said that she liked living in the facility and was happy. She said there were a few other residents who yelled a lot. Resident #2 said she liked playing Bingo and looked forward to playing it.Resident #2 said she recalled times when she was told by staff to return to her room, but she could not remember when or why.C. Record reviewThe behaviors care plan, initiated 4/13/22 and revised 8/6/24, identified Resident #2 had behaviors related to feeding and pushing other residents in their wheelchairs. Pertinent interventions included approaching the resident in a calm manner and telling her it was unsafe to feed other residents (reviewed 8/6/24), offering and providing the resident activities of interest for positive interactions (revised 8/6/24), providing the resident with positive feedback when her behavior was appropriate and emphasizing positive aspects of compliance (revised 8/6/24).-Review of the comprehensive care plan did not identify an intervention for sending the resident to her room when she displayed behaviors. Cross reference F744: failure to provide person-centered dementia care.The 6/10/25 nursing progress note revealed Resident #2 was asked to eat her lunch in her room due to her behavior in the dining room, which included yelling and taunting other residents. The 7/4/25 nursing progress note revealed Resident #2 was redirected by staff for her behavior and told that if she was not nice, she had to go to her room.III. Staff interviewsLicensed practical nurse (LPN) #1 was interviewed on 7/24/25 at 1:55 p.m. LPN #1 said when a resident was disruptive she spoke with the resident and gave them a warning. She said she would tell the residents that they would be removed from the activity or returned to their room. She said she made her decisions on behavior management based on what she thought was appropriate for each situation. The director of nursing (DON) was interviewed on 7/22/25 at 3:10 p.m. The DON said the facility did not have a policy for resident disciplinary action that allowed the staff to send residents to their rooms and cancel participation in future activities. The DON said when residents had disruptive behaviors, it was necessary to separate the residents for the safety of others. The DON said that if residents were redirected, the resident should be offered an alternate activity or intervention and should not be sent to their room.

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	065399	A. Building B. Wing	07/24/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Rio Grande Rehabilitation and Healthcare Center	39 Calle Miller LA Jara, CO 81140

For information on the nursing home's plan to correct this deficiency, please contact the nursing home or the state survey agency.

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0744 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide the appropriate treatment and services to a resident who displays or is diagnosed with dementia. (continued on next page)

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	065399	A. Building B. Wing	07/24/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Rio Grande Rehabilitation and Healthcare Center	39 Calle Miller LA Jara, CO 81140

For information on the nursing home's plan to correct this deficiency, please contact the nursing home or the state survey agency.

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0744 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on interviews and record review, the facility failed to provide person-centered dementia care and services for two (#2 and #1) of seven residents reviewed for dementia care out of seven sample residents.Specifically, the facility failed to:-Implement appropriate person-centered dementia interventions for Resident #2; and, -Implement person-centered dementia interventions for Resident #1.Findings include: I. Facility policy and procedureThe Dementia Clinical Protocol policy, undated, was provided by the nursing home administrator (NHA) on 7/24/2 at 3:20 p.m. It read in pertinent part, For individuals with dementia, the interdisciplinary team (IDT) will identify a resident-centered care plan to maximize function and quality of life.Direct care staff will support the resident with initiating and completing activities and tasks of daily living. The IDT will identify and document resident condition and level of support needed during care planning and review changing needs as they arise. The physician will order appropriate interventions to address significant behavioral symptoms. The staff will monitor the individual with dementia for changes in condition. The physician and staff will review the effectiveness and complications of medications used and adjust medications as needed.II. Resident #2A. Resident statusResident #2, age greater than 65, was admitted on [DATE]. According to the July 2025 computerized physician's orders (CPO), diagnoses included unspecified dementia with unspecified severity without behavioral disturbance and other specified depressive episodes.The 4/6/25 minimum data set (MDS) assessment revealed Resident #2 had short-term and long-term memory problems per staff assessment. Resident #2 required supervision from staff for activities of daily living and was independent with mobility.The MDS assessment indicated the resident had no behavioral symptoms during the look back period.B. Record reviewThe behavior care plan, initiated 4/13/22 and revised 8/6/24, identified Resident #2 had behaviors related to feeding and pushing other residents in their wheelchairs. Pertinent interventions included approaching the resident in a calm manner and telling her it was unsafe to feed other residents (revised 8/6/24), offering and providing the resident activities of interest for positive interactions (revised 8/6/24), providing the resident with positive feedback when her behavior was appropriate and emphasizing positive aspects of compliance (revised 8/6/24).Review of the July 2025 CPO revealed a physician's order that indicated for the staff to monitor the resident for behaviors of hitting, kicking, verbal aggression, and taunting behaviors, and if behaviors were observed, enter a progress note, ordered 6/9/25.The 6/10/25 nursing progress note revealed that Resident #2 was asked to eat her lunch in her room due to her behavior in the dining room, which included yelling and taunting other residents. Cross reference F603: failure to be free from involuntary seclusion. -The facility failed to implement appropriate person-centered interventions to address Resident #2's behaviors. The 7/4/25 nursing progress note revealed Resident #2 was redirected by staff for her behavior and told that if she was not nice, she had to go to her room. -The facility failed to implement appropriate person-centered interventions to address Resident #2's behaviors. 4. Resident interview and observationResident #2 was observed and interviewed on 7/24/25 at 1:22 p.m. in her room. Resident #2 sat in her recliner and held a needlepoint craft. Resident #2 said that she liked living in the facility and was happy. She said there were a few other residents who yelled a lot. Resident #2 said she loved playing Bingo and looked forward to playing it.Resident #2 said she recalled times she was told to return to her room, but she could not remember when or why. Resident #2 said she was offered another needlepoint craft to work on in her room. Resident #2 said she enjoyed the needlepoint but was concerned she might miss the bingo games.III. Resident #1 A. Resident status Resident #1, age greater than 65, was admitted on [DATE] and discharged to another facility on 6/30/25. According to the June 2025 CPO, diagnoses included dementia with unspecified severity, with agitation and Alzheimer's disease.The 6/26/25 MDS assessment revealed Resident #1 was moderately impaired with daily decision making, had short and long-term memory problems, and was severely impaired with cognitive skills for daily decision making per staff assessment. During the look-back period, Resident #1 had short and long-term memory problems, inattention, and disorganized thinking were continuously present, and the resident wandered daily.The MDS assessment identified Resident #1 had no physical, verbal, or other behavioral symptoms directed toward others during the look-back period. Resident #1 required moderate to substantial assistance from staff for activities of daily living, and required supervision or touching assistance for standing, transferring, and walking.B. Record reviewThe behavior and wandering care plan, initiated 3/27/25, revealed the resident had exit-seeking behaviors and wandered throughout the facility with no sense of direction. Pertinent