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	11/06/2025

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 0600 Level of Harm - Actual harm Residents Affected - Few	Protect each resident from all types of abuse such as physical, mental, sexual abuse, physical punishment, and neglect by anybody. (continued on next page)

Any deficiency statement ending with an asterisk (*) denotes a deficiency which the institution may be excused from correcting providing it is determined that other safeguards provide sufficient protection to the patients. (See instructions.) Except for nursing homes, the findings stated above are disclosable 90 days following the date of survey whether or not a plan of correction is provided. For nursing homes, the above findings and plans of correction are disclosable 14 days following the date these documents are made available to the facility. If deficiencies are cited, an approved plan of correction is requisite to continued program participation.

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE	TITLE	(X6) DATE

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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0600 Level of Harm - 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 residents were kept free from abuse for one (#10) of three residents reviewed for abuse out of 11 sample residents.Resident #10 was admitted on [DATE] with diagnoses of autistic disorder, dementia and depression.Resident #11 was admitted on [DATE] with diagnoses of dementia and schizophrenia (mental illness).On 9/7/25, Resident #10 entered the facility from outside. Resident #11 approached Resident #10 and pushed him to the floor. Resident #10 complained of left leg pain and was transferred to the hospital where he was diagnosed with a femur fracture that required surgical repair. Specifically, the facility failed to protect Resident #10 from physical abuse by Resident #11. Findings include:I. Facility policy and procedureThe Resident Rights, dated December 2021, was provided by the nursing home administrator (NHA) on 11/3/25 at 2:30 p.m. It read in pertinent part: Federal and state laws guarantee certain basic rights to all residents. These rights include the right to be free from abuse.II. Incident of physical abuse by Resident #11 towards Resident #10 on 9/7/25The 9/7/25 facility investigation revealed that on 9/7/25 at 11:10 a.m. a staff member observed Resident #10 fall. The investigation revealed the nurse on duty responded. Resident #10 reported he entered the facility from outside, Resident #11 approached him and pushed him down to the floor. The facility staff immediately separated the residents for safety. Resident #10 reported he had pain in his leg and he was transferred to the emergency department for evaluation. Resident #10 was diagnosed with a fractured femur which required surgery to repair the fracture. The investigation documented the NHA interviewed Resident #10 on 9/7/25. Resident #10 said he was very angry about the incident. He said he had not had any previous altercations with Resident #11.The investigation documented Resident #11 was assessed by the nurse and had no injuries. Resident #11 was placed on safety checks for 72 hours. The investigation documented the NHA interviewed Resident #11 on 9/7/25. Resident #11 denied that there had been any conflict with Resident #10 and said he did not do anything to Resident #10. The investigation documented the NHA reviewed camera footage on 9/7/25 and observed Resident #11 push Resident #10 to the floor. The investigation documented that Resident #11 was transferred on 9/8/25 to a new room in the facility, on a different hallway to keep the residents separated. The NHA interviewed four facility residents and they said they had no concerns about physical abuse and said they felt safe at the facility.The investigation documented the facility substantiated the incident of physical abuse. III. Resident #10 (victim)A. Resident statusResident #10, age greater than 65, was admitted on [DATE], discharged to the hospital 9/7/25 and readmitted on [DATE]. According to the November 2025 computerized physician's orders (CPO), diagnoses included fracture of the left femur, autistic disorder, dementia and depression.The 10/6/25 minimum data set (MDS) assessment revealed the resident had moderate cognitive impairments with a brief interview for mental status (BIMS) score 12 out of 15.The assessment documented Resident #10 had no behaviors directed toward himself or others during the assessment period. Resident #10 required set up assistance/supervision for bed mobility, transfers, walking in his room, hallway, and unit. The assessment identified Resident #10 used a cane or crutch for walking. B. Resident interviewResident #10 was interviewed on 11/5/25 at 2:45 p.m. Resident #10 said he remembered when Resident #11 pushed him to the floor. Resident #10 said Resident #11 approached him as he entered the facility from the outside patio and pushed him, which caused him to fall. Resident #10 said he was upset his femur was fractured and that he had to have surgery. Resident #10 said he was healing and was working towards gaining strength while walking. Resident #10 said he had no concerns and was not afraid of Resident #11 although he was cautious about being pushed by anyone. Resident #10 said there were no previous altercations between himself and Resident #11. C. Record reviewThe behavior care plan, revised 8/21/24, revealed Resident #10 had the potential for verbal aggression. Pertinent interventions included monitoring target behavior (8/21/24), administering medications as prescribed (7/14/24) and redirecting the resident to his room or a calm area (7/14/24).The 9/7/25 nurse progress note revealed Resident #10 yelled out why did you do that. The nurse responded. Resident #10 told the nurse he was pushed by Resident #11 and he fell. The nurse completed an assessment and Resident #10 was transferred to the hospital for evaluation of leg pain.The 9/17/25 nurse progress note revealed Resident #10 returned to the facility with physician's orders for physical and occupational therapy for balance and strengthening.IV. Resident #11 (assailant)A. Resident statusResident #11, age greater than 65, was admitted on [DATE]. According to the November 2025 CPO, diagnoses included dementia and schizophrenia.The 10/6/25 MDS assessment

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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 0684 Level of Harm - Actual harm Residents Affected - Few	Provide appropriate treatment and care according to orders, resident's preferences and goals. (continued on next page)

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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0684 Level of Harm - Actual harm Residents Affected - Few	**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on , observations, record review and interviews, the facility failed to ensure residents received treatment and care in accordance with professional standards for two (#1 and #2) of five residents reviewed for wound care and weekly skin assessments out of 11 sample residents.Resident #1 was admitted on [DATE] and discharged to the hospital on [DATE]. Resident #1 had a diagnosis of heart failure, multiple sclerosis, dementia and diabetes. Resident #1 had a history of hemorrhoids and was receiving as needed topical medication. Upon admission to the hospital on [DATE], it was discovered that Resident #1 had a perianal abscess which required surgery and intravenous (IV) antibiotics. Review of the facility documentation revealed the facility failed to complete skin assessments to monitor the status of the resident's hemorrhoids. Specifically, the facility failed to: -Complete weekly skin assessments for Resident #1, who had developed a perianal abscess; and,-Obtain wound care physician's orders for Resident #2.Findings include:I. Facility policy and procedureThe Skin Inspection policy, undated, was received from the nursing home administrator (NHA) on 11/6/25 at 2:37 p.m. It read in pertinent part, Every seven to 10 days each resident will have a head to toe skin inspection. The skin inspection will be documented within the EHR (electronic health record), using the skin inspection evaluation. The Wound Care policy and procedure, dated 2001, was received by the director of nursing (DON) on 11/3/25 at 2:30 p.m. It read in pertinent part, The purpose of this procedure is to provide guidance for the care of wounds to promote healing. Procedure instructions:-Verfify there is a physician's order for the procedure.-Review the care plan to assess for special needs of the resident; -Document the type of wound car given; and,-Document all assessment data (wound bed color, size, drainage) obtained when inspecting the wound.II. Resident #1A. Resident statusResident #1, age greater than 65, was admitted on [DATE], discharged to the hospital on 9/30/25, readmitted to the facility on [DATE] and discharged again to the hospital on [DATE]. According to the November 2025 computerized physician orders (CPO), diagnoses included heart failure, progressive multiple sclerosis, dementia and diabetes mellitus.The 10/22/25 minimum data set (MDS) assessment revealed the resident had moderate cognitive impairments with a brief interview for mental status (BIMS) score of eight out of 15. Resident #1 required substantial to maximum assistance from staff for dressing and bed mobility and was dependent on staff for transfers.The MDS assessment documented Resident #1 had no skin problems, received applications of ointments and medication during the assessment look-back period. B. Hospital nurse interviewThe hospital nurse was interviewed by telephone on 11/4/25 at 10:00 a.m. The hospital nurse said she was working on 11/1/25 when Resident #1 arrived in the emergency room. The hospital nurse said the facility reported Resident #1 had a hemorrhoid and wanted to be transferred to the emergency department. The hospital nurse said the resident arrived at the hospital with a pressure injury on his buttocks. The nurse said the resident was transferred to another hospital for higher level of care for surgical treatment of the buttocks wound.B. Record reviewThe skin integrity care plan, initiated 7/16/21, revealed Resident #1 had a risk for impaired skin integrity. Pertinent interventions included assisting with turning and repositioning as needed (6/11/25), completing skin inspections every seven to 10 days and as needed (3/23/23), notifying the physician of new areas of impaired skin integrity (3/3/23), implementing a pressure redistribution mattress to the resident's bed (3/3/23), implementing a pressure relieving pad for the resident's wheelchair (9/30/25) and reducing friction or shearing forces (6/11/25). Review of the November 2025 CPO revealed a physician's order for hemorrhoidal relief external cream 5% (percent) lidocaine (anorectal), apply to anal area topically every eight hours as needed for hemorrhoids, ordered 5/27/25.-Review of Resident #1's comprehensive care plan did not reveal documentation regarding the resident's hemorrhoids. -Review of Resident #1's electronic medical record (EMR) did not reveal documentation indicating skin assessments were completed from 10/2/25 to 10/24/25.The 11/1/25 nurse progress note documented Resident #1 complained of hemorrhoid pain and requested to go to bed. The resident's vital signs were taken. The resident's temperature was 97.5 degrees Fahrenheit, heart rate was 56 beats per minute (bpm), respirations were 26 breaths per minute, and blood pressure was 82/48 millimeters of mercury (mmHg) (normal blood pressure is 120/80). The nurse notified the physician of the resident's status and gave an order to have the resident transferred to the emergency department for evaluation. The 11/1/25 emergency department's physician documented Resident #1 reported not feeling well for several days and was sent to the emergency department because his blood pressure was low. The 11/1/25 computerized tomography (CT) scan completed at the emergency

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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 0690 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	Provide appropriate care for residents who are continent or incontinent of bowel/bladder, appropriate catheter care, and appropriate care to prevent urinary tract infections. (continued on next page)

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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0690 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observations, record review and interviews, the facility failed to ensure residents received treatment and care in accordance with professional standards of practice for one (#2) of seven residents reviewed for foley catheter care and catheter assessments out of eleven sample residents.Specifically, the facility failed to ensure staff were appropriately trained in the care needs of a resident with quadriplegia and effectively monitoring Resident #2, who had an indwelling foley catheter for signs and symptoms of urinary retention. This resulted in the resident being transferred to the hospital where she was admitted to the hospital's intensive care unit for a higher level of care. Resident #2, was admitted [DATE] with diagnoses of quadriplegia, acute renal failure, dementia, dysfunctional bladder and severe cognitive impairment. Resident #2 was admitted with an indwelling foley catheter for continuous bladder drainage. On 10/31/25 at 5:29 a.m. a night shift CNA documented Resident #2 had a urine output volume of 300 ml emptied from the urine collection bag for the overnight shift of 10/30/25 into 10/31/25. On 10/31/25 at 5:59 p.m. a day shift CNA documented Resident #2 had a urine output volume of 300 ml of urine emptied from the urine collection bag for the day shift on 10/31/25.Twelve hours later on 11/1/25 at 5:59 a.m. a night shift CNA documented Resident #2 had zero ml of urine emptied from the urine collection bag.-Resident #2 had a total of 300 ml of urine output for the 24-hour period between 10/31/25 at 5:29 a.m. and 11/1/25 at 5:59 a.m. However, the resident's decreased urinary output was not communicated to the nurse or the physician and Resident #2 was not assessed for any complications of urinary retention. The facility was not conducting nurse assessments or monitoring the resident for impaired urinary elimination or urine characteristics that could indicate a concern regarding the resident's urinary status.On 11/1/25 at 1:50 p.m. the nurse was notified by staff that Resident #2 was not responding or waking up (to verbal stimuli). The nurse assessed Resident #2 and found the resident with respiratory distress, but the resident opened and closed her eyes to physical stimuli. The resident's vital signs were as follows: blood pressure was 159/82 millimeters of mercury (mmHg), heart rate was 13 bpm (beats per minute), respirations were 22 breaths per minute, temperature was 98.6 and the resident's oxygen saturation (oxygen level in the blood) was 75% on room air. The nurse called 911 and the resident was transferred to the hospital emergency department. On 11/1/25, after being evaluated by the emergency department, Resident #2 was admitted to the hospital for altered mental status and required respiratory intubation (inserting a tube into the airway) for airway protection. The foley catheter was removed from the bladder and 2000 milliliters (ml) of bloody urine with pus was drained. The computed tomography (CT) scan in the emergency department revealed the resident had bilateral hydronephrosis (swelling of both kidneys due to a build up of urine), and debris in the bladder. Resident #2 was diagnosed with severe sepsis (the body's extreme reaction to an infection, which can lead to organ failure, tissue damage and death if not treated promptly), acute respiratory failure, and myocardial infarction (heart attack), and required placement on a ventilator. Resident #2 was stabilized and transferred to a different hospital's intensive care unit for higher level of care. Staff interviews on 11/4/25, during the survey, revealed staff were lacking important knowledge and training in regards to caring for residents that had indwelling foley catheters and those with dysfunctional bladders, as well as the care needs of residents with quadriplegia.Findings include:I. Findings of immediate jeopardyOn 10/31/25 at 5:29 a.m. a night shift CNA documented Resident #2 had a urine output volume of 300 ml emptied from the urine collection bag for the overnight shift of 10/30/25 into 10/31/25. On 10/31/25 at 5:59 p.m. a day shift CNA documented Resident #2 had a urine output volume of 300 ml of urine emptied from the urine collection bag for the day shift on 10/31/25.Twelve hours later on 11/1/25 at 5:59 a.m. a night shift CNA documented Resident #2 had zero ml of urine emptied from the urine collection bag.-Resident #2 had a total of 300 ml of urine output for the 24-hour period between 10/31/25 at 5:29 a.m. and 11/1/25 at 5:59 a.m. However, the resident's decreased urinary output was not communicated to the nurse or the physician and the resident was not assessed for any complications of urinary retention. The facility was not conducting nurse assessments or monitoring the resident for impaired urinary elimination or urine characteristics (color, odor, clarity) that could indicate a concern regarding the resident's urinary status.On 11/1/25 at 1:50 p.m. the nurse was notified by staff that Resident #2 was not responding or waking up (to verbal stimuli). The nurse assessed Resident #2 and found the resident with respiratory distress, but the resident opened and closed her eyes to physical stimuli. The resident's vital signs were as follows: blood pressure was 159/82 mmHg, heart rate was 131 bpm, respirations were 22 breaths per minute, temperature