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	04/22/2026

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

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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. Based on observations and interviews, the facility failed to store, prepare, distribute and serve food in accordance with professional standards for food service safety in the main kitchen. Specifically, the facility failed to:-Ensure staff did not touch ready-to-eat food with their bare hands; -Ensure staff performed proper hand hygiene during meal service;-Ensure expired food was discarded;-Ensure equipment was in good repair; and,-Ensure artificial nails and jewelry were not worn. Findings include: I. Failure to ensure staff used proper hand hygiene and did not touch ready-to-eat foods with bare hands during meal service.A. Professional referenceThe Colorado Department of Public Health and Environment Colorado Retail Food Establishment Rules and Regulations, revised 3/16/24, was retrieved on 4/29/26. It revealed in pertinent part, 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; using tobacco products, eating, or drinking; after handling soiled equipment or utensils; during food preparation, as often as necessary to remove soil and contamination and to prevent cross contamination when changing tasks; before donning gloves to initiate a task that involves working with food; and after engaging in other activities that contaminate the hands. (2-301.15) Food employees may not contact exposed, ready-to-eat food with their bare hands and shall use suitable utensils such as deli tissue, spatulas, tongs, single-use gloves, or dispensing equipment. (3-301.11)B. Facility policy and procedureThe Food Preparation and Service policy and procedure, revised November 2022, was provided by the NHA on 4/22/26 at 6:38 p.m. It read in pertinent part, Food and nutrition services staff, including nursing services personnel, wash their hands before serving food to residents. Employees also wash their hands after collecting soiled plates and food waste prior to handling food trays. Bare hand contact with food is prohibited. Gloves are worn when handling food directly and changed between tasks. Disposable gloves are single-use items and are discarded after each use.C. ObservationsDuring a continuous observation on 4/19/26, beginning at 4:04 p.m. and ending at 5:17 p.m., the following was observed:At 4:04 p.m. an unidentified DA was offering hand sanitizer to residents while taking their orders. She was pulling a small spray hand sanitizer out of her pocket then placing it back into her pocket. At 4:10 p.m. DA #4 took a cup of iced tea from a resident, added more ice to the cup and gave it back to the resident by the rim of the glass. At 4:40 p.m. licensed practical nurse (LPN) #3 cut an unidentified female resident's patty melt and handed a slice of the sandwich to the resident with her bare hand. LPN #3 then began assisting another resident at the same table. She did not sanitize her hands before handling the food. At 4:42 p.m. LPN #3 handed another slice of the patty melt to the unidentified female resident using her bare hands. She did not sanitize her hands prior to handling the food or after assisting the other resident at the table. At 4:56 p.m. DA #4 continued to pass drinks while touching the rims of the cups without sanitizing her hands.At 5:05 p.m. DA #4 tore a resident's patty melt into two smaller pieces for the resident with her bare hands. She then handed one of the two pieces to the resident and placed the (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
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F 0812 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	other piece on the plate. The resident then began to eat the patty melt. During a continuous observation on 4/21/26, beginning at 10:34 a.m. and ending at 12:04 p.m., the following was observed:At 10:45 a.m. DA #1 walked into the dishroom from the dining room, then entered the main kitchen. He began putting away the snacks that were sitting on the prep table. He did not wash his hands when he entered the kitchenAt 10:45 a.m. CK #1 did not wash her hands when she was finished at the two compartment sink. At 10:51 a.m. CK #1 scooped shrimp from the steam table into a bowl, she then dumped the shrimp back into the pan on the steam table. -CK #1 did not wash her hands prior to scooping the shrimp.At 10:53 a.m. CK #1 moved the dishes from the two-compartment sink into the dishroom and ran them through the dishwasher. At 11:01 a.m. DA #1 exited the bathroom that was in the kitchen and did not wash his hands. He then went into the dining room to serve drinks and take orders. At 11:16 a.m. without washing her hands after touching dirty dishes, CK #1 wiped down the service table and service line after she finished taking the meal temperatures. She then grabbed the recipe binder to check for scoop serving sizes. At 11:22 a.m. CK #1 started serving room trays. She was not wearing gloves. She then cut a slice of corn bread, used tongs to place it on the plate. She set the knife directly on top of the corn bread with the handle touching the bread. At 11:25 a.m. CK #1 turned and placed some frozen chicken in the fryer basket, then using her bare hands put the fryer basket into the fryer. At 11:26 a.m. without washing her hands CK#1 pulled the fryer basket out of the fryer, she pulled the chicken out of the fryer. She did not take the temperature of the chicken. She was using her bare hands, she did not wash her hands. At 11:27 a.m. CK #1 cut a piece of corn bread, then placed the knife back in the pan of corn bread. The handle of the knife was touching the corn bread. At 11:29 a.m. DA #1 was touching the rim of a cup with his bare hand. At 11:33 a.m. CK #2 came to help CK #1 serve the meal. CK #2 wiped her bare hands on the back of her pants and was touching meal tickets. At 11:35 a.m. without washing her hands, CK #2 was cutting corn bread with her right hand and had a meal ticket in her left hand. Using the tongs she placed the corn bread on the plate, she then took the meal ticket that was in her left hand and slid it underneath the corn bread so the bread was holding the ticket in place on the plate with the other food. At 11:40 a.m. CK #2 wiped her hands on her shirt and grabbed meal tickets. She did not wash her hands. At 11:41 a.m. without washing her hands, CK #2 made a grilled cheese. She cut the grilled cheese at a diagonal. She used her right hand to cut the grilled cheese and held the grilled cheese in place with her left hand. At 11:44 a.m. DA #1 came into the kitchen, did not wash his hands and grabbed a stack of red cups. He touched the rims of some of the cups when he grabbed the stack, and went back into the dining room. At 11:45 a.m. CK #2 was plating a meal, she touched some rice and mechanical soft shrimp with her bare hands when it spilled over and touched in the middle of the plate. She then placed the meal ticket underneath the corn bread on the plate. The plate was then placed in the window to be served to the resident. At 11:46 a.m. CK #2 was touching rice on a plate with her bare hands, she then wiped her hands on her shirt. She did not wash her hands. At 11:47 a.m. without washing her hands, CK #2 touched pieces of shrimp with her bare hands while she was plating the food. At 11: 49 a.m. CK #2 was touching meal tickets, then touching squash on a plate, and then placed the meal ticket underneath the corn bread. At 11:50 a.m. a meal ticket fell to the floor, CK #2 picked it up off of the floor with her bare hands, she then placed the ticket on the service counter with the other tickets. She did not wash her hands. She continued to plate food. At 11:52 a.m. CK #2 was plating food, she touched the rice, the squash and the shrimp with her bare hands, she moved the food on the plate so the food was not touching. She then wiped her hands on her shirt. She did not wash her hands. At 11:53 a.m. without washing her hands CK #2 touched the shrimp, and corn bread with her bare hands then served the plate. At 11:54 a.m. CK #2 went to the refrigerator, grabbed a premade peanut butter and jelly sandwich that was wrapped in plastic wrap, she unwrapped the sandwich and placed it on a plate. CK #2 then went to the freezer and grabbed a bag of french fries. CK #2 then opened the bag of fries and with her left hand she held the bag and with her right bare hand she reached into the bag and pulled two to three handfuls of french fries and put them in the fryer basket then dropped the fries (continued on next page)

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F 0812 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	into the fryer. She replaced the bag of fries into the freezer. She did not wash her hands. At 11:57 a.m. CK #2 pulled the basket of fries out of the fryer, using her bare hands. She then touched some of the fries with her bare fingers to see if they were done. After touching the French fries she plated them. She did not wash her hands before or after touching the french fries. At 11:58 a.m. CK #2 went to the refrigerator and grabbed one slice of cheese with her bare hand, she then went to the freezer and grabbed a frozen hamburger patty. She then went to the stove and put the frozen hamburger patty on a skillet, she then placed the slice of cheese that she had been holding in her hand on the frozen hamburger patty. She then pulled the cheese off of the frozen hamburger patty and proceeded to hold the slice of cheese in her left hand while the hamburger patty cooked. At 12:04 p.m. CK #2 placed the slice of cheese that she had been holding in her bare hand on to the top of the cooked hamburger. She then placed the hamburger onto the bun and then plated squash and rice with the hamburger. CK #2 touched the rice and squash with her bare hands. She did not wash her hands. D. Staff interviewsCK #1 was interviewed on 4/21/26 at 12:19 p.m. She said staff were supposed to wash their hands whenever they changed tasks. She said staff should not touch ready-to-eat foods with their bare hands. She said she had not realized she had touched the cheese and bread during meal service. CK #2 was interviewed on 4/21/26 at 12:24 p.m. She said staff should wash their hands anytime their hands come into contact with anything that was not clean or when they go outside. She said she should not have wiped her hands on her shirt or clothing. She said she should not have touched ready-to-eat foods with her bare hands. DA #3 was interviewed on 4/21/26 at 12:30 p.m. She said staff should wash their hands any time they give out food to the residents and when staff goes in and out of the dishroom. She said when she was working the dishroom she always washed her hands when she went from dirty to clean dishes. DA #1 was interviewed on 4/21/26 at 12:33 p.m. He said staff should wash or sanitize their hands every three plates when they are serving residents or every two minutes. He said staff should wash their hands when they come out of the bathroom, when they leave or comeback into the kitchen. The DM was interviewed on 4/21/26 at 12:35 p.m. She said she expected her staff to wash their hands when they walk into the kitchen, before and after putting and taking off gloves, coming out of the bathroom, and when they change tasks. She said that no one should be touching ready-to-eat foods with their bare hands.II. Failure to discard expired foodA. Professional referenceThe Colorado Department of Public Health and Environment Colorado Retail Food Establishment Rules and Regulations, revised 3/16/24, was retrieved on 4/29/26. It revealed in pertinent part, A food that is unsafe, adulterated, or not honestly presented as specified under S 3-101.11shall be discarded or reconditioned according to an approved procedure. (3-701.11)B. ObservationsOn 4/19/26 at 1:01 p.m. there was a plastic bag on the bread rack in the dry storage. The bag contained at least one identifiable croissant; the other bread-like substance that was in the bag was covered in dark green/ black fuzz. On 4/21/26 at 12:10 p.m. the same plastic bag with the one identifiable croissant remained on the bread rack in the dry storage. C. Staff interviewThe dietary manager (DM) was interviewed on 4/19/26 at 12:10 p.m. She said the bag of croissants should have been thrown out. She said she had not seen the bag in the dry storage. III. Failure to ensure equipment was in good repairA. Professional referenceThe Colorado Department of Public Health and Environment Colorado Retail Food Establishment Rules and Regulations, revised 3/16/24, was retrieved on 4/29/26. It revealed in pertinent part, Exhaust ventilation hood systems in food preparation and dishware washing areas including components such as hoods, fans, guards, and ducting shall be designed to prevent grease or condensation from dripping onto food, equipment, utensils, linens, and single-service and single-use articles. (4-204.11)B. ObservationsOn 4/19/26 at 1:05 p.m. half of a wooden pencil was holding up the drip pan for grease in the top left corner of the hood ventilation system above the grill. On 4/21/26 at 12:10 p.m. the same half wooden pencil was still holding up the drip pan for grease in the top left corner of the hood ventilation system above the grill. C. Staff interviewsThe DM was interviewed on 4/21/26 at 12:35 p.m. She said she did not know why the pencil was there holding up the drip pan. She said she was unsure of who or why someone (continued on next page)

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	065399	A. Building B. Wing	04/22/2026

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F 0812 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	put the pencil there. She said she thought a company came out quarterly to clean the hoods. She said the maintenance director was the one who was in charge of scheduling the hood cleaning. The nursing home administrator (NHA) was interviewed on 4/21/26 at 4:34 p.m. He said the maintenance director was out due to an injury and was only allowed to work a certain amount of hours per week. He said the last time the company came out was in March 2026. He said they come out every six months. He said this was not the first time that the company did something wrong. He said he was not sure why the pencil was there. He said there should be a notch that the pan slides into, he said they must have broken it and used the pencil to fix it. IV. Failed to ensure artificial nails and jewelry were not wornA. Professional referenceThe Colorado Department of Public Health and Environment Colorado Retail Food Establishment Rules and Regulations, revised 3/16/24, was retrieved on 4/29/26. It revealed in pertinent part, Unless wearing intact gloves in good repair, a food employee may not wear fingernail polish or artificial fingernails when working with exposed food. (2-302.11) Except for a plain ring such as a wedding band, while preparing food, food employees may not wear jewelry including medical information jewelry on their arms and hands. (2-303.11)B. Facility policy and procedureThe Food Preparation and Service policy and procedure, revised November 2022, was provided by the NHA on 4/22/26 at 6:38 p.m. It read in pertinent part, Food and nutrition services staff keep fingernails trimmed and clean. Jewelry is worn minimally and hand jewelry (wedding ring) is covered with gloves. C. ObservationsDuring a continuous observation on 4/19/26, beginning at 4:04 p.m. and ending at 5:17 p.m., the following was observed:At 4:29 p.m. dietary aide (DA) #4 was taking meal orders, passing drinks, and passing meals to residents. She had artificial nails on that were approximately half an inch long and multiple fabric-type bracelets on her wrists. D. Staff interviewThe DM was interviewed on 4/21/26 at 12:35 p.m. She said she was not aware that DA #4 had artificial nails and wore multiple bracelets. She said she expects her staff to have trimmed nails or wear gloves with artificial nails. She said she expects her staff to wear minimal jewelry when serving meals. She said it was due to infection control.

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	065399	A. Building B. Wing	04/22/2026

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F 0555 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Honor the resident's right to choose his or her attending physician. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on interviews and record review, the facility failed to ensure three (#15, #28 and #30) of five residents out of 31 sample residents had the right to choose their own attending physician. Specifically, the facility failed to allow Resident #15, Resident #28 and Resident #30 to choose their primary care physician while the resident resided in the facility.Findings include: I. Facility policy and procedure The Choice of Attending Physician policy and procedure, revised November 2025, was provided by the nursing home administrator (NHA) on 4/22/26 at 5:09 p.m. It revealed in pertinent part, Residents have the right to choose their own attending physician or licensed healthcare provider who meets the requirements and responsibilities of an attending physician/provider. If the resident does not choose their own physician or provider, the resident is informed in writing of the name, specialty, and contact information of their attending physician or provider during the admission process, any time the information changes or upon the resident's/representative's request.II. Resident #15A. Resident status Resident #15, age [AGE], was admitted on [DATE]. According to the April 2026 computerized physician orders (CPO), diagnoses included chronic obstructive pulmonary disease (COPD - a progressive lung disease, also known as emphysema), cirrhosis of the liver and osteoarthritis. The 3/14/26 quarterly minimum data set (MDS) assessment revealed the resident was cognitively intact with a brief interview for mental status (BIMS) score of 15 out of 15. The 1/27/26 annual MDS assessment revealed it was very important to the resident to take care of her personal belongings or things, and somewhat important to have family or a close friend involved in discussions about her care. B. Resident interview Resident #15 was interviewed on 4/21/26 at 10:02 a.m., during a group interview with Resident #28, Resident #30, Resident #44 and Resident #32. Resident #15 said she had a primary care physician in town she wanted to continue to see while in the facility. She said she was told she was not able to see that physician and could only see the medical director (MD) at the facility. Resident #15 said she did not remember who told her that but it was someone who was part of the nursing staff. C. Record review -Review of Resident #15's electronic medical record (EMR), including the admission agreement, revealed there was no documentation to indicate the resident was provided with a choice of who she wanted as her primary care physician. III. Resident #28 A. Resident status Resident #28, age [AGE], was admitted on [DATE]. According to the April 2026 CPO, diagnoses included type 2 diabetes mellitus, asthma, osteoarthritis (degenerative joint disease) and transient ischemic attack and cerebral infarction (TIA - a ministroke). The 3/2/26 quarterly MDS assessment revealed the resident was cognitively intact with a BMS score of 15 out of 15. The 6/19/25 annual MDS assessment revealed it was very important to the resident to take care of her personal belongings or things, and very important to have family or a close friend involved in discussions about her care. B. Resident interview Resident #28 was interviewed on 4/21/26 at 10:02 a.m., during a group interview with Resident #15, Resident #30, Resident #44 and Resident #32. Resident #28 said she did not have a choice in who her physician could be while at the facility. Resident #28 said she had to see the facility's MD. C. Record review-Review of Resident #28's EMR, including the admission agreement, revealed there was no documentation to indicate the resident was provided with a choice of who she wanted as her primary care physician. IV. Resident #30 A. Resident status Resident #30, age [AGE], was admitted on [DATE]. According to the April 2026 CPO, diagnoses included type 2 diabetes mellitus, wedge compression fracture of T11-T12 (thoracic) vertebrae and third lumbar vertebra (a spinal injury that causes a hunchback) and hypertension (high blood pressure). The 3/12/26 quarterly MDS assessment revealed the resident was cognitively intact with a BIMS score of 15 out of 15. The 12/18/25 annual MDS assessment revealed it was very important to the resident to take care of his personal belongings or things, and somewhat important to have family or a close friend involved in discussions about his care. B. Resident interview Resident #30 was interviewed on 4/21/26 at 10:02 a.m., during a group interview with Resident #15, Resident (continued on next page)

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	065399	A. Building B. Wing	04/22/2026

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
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F 0555 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	#28, Resident #44 and Resident #32. Resident #30 said he did not have a choice in who his physician could be while at the facility. Resident #30 said he had to see the facility's MD. C. Record review-Review of Resident #30's EMR, including the admission agreement, revealed there was no documentation to indicate the resident was provided with a choice of who he wanted as his primary care physician. V. Staff interviewsThe NHA was interviewed on 4/22/26 at 1:16 p.m. The NHA said it was the residents' choice for who they wanted for their physician. He said residents were able to choose who they wanted as their attending physician when they were admitted to the facility. He said the attending physician choice was reviewed in the admission agreement. The NHA said the facility had one physician the residents could choose from when they were admitted to the facility. The NHA said he was not aware of any residents who wanted to change physicians or wanted to see their primary physician. The NHA was familiar with Resident #15, Resident #28 and Resident #30 and said he did not know that any of them wanted a different attending physician.

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	065399	A. Building B. Wing	04/22/2026

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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 0605 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Prevent the use of unnecessary psychotropic medications or use medications that may restrain a resident's ability to function. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on record review and interviews, the facility failed to ensure four (#1, #41, #34 and #22) of nine residents were free from chemical restraints out of 31 sample residents. Specifically, the facility failed to:-Document a physician's rationale for Resident #1, #41, and #34's psychotropic medications in order to justify the continued use of the medications;-Document resident specific care approaches, to include medication specific target behaviors and person-centered interventions for Resident #1, #41, and #34's psychotropic medications; and, -Ensure Resident #22's as needed (PRN) antipsychotic medication had corresponding documentation of identified behaviors and use of non-pharmological interventions.Findings include:I. Facility policy and procedureThe Psychotropic Medication Use policy, revised February 2025, was provided by the nursing home administrator (NHA) on [DATE] at 10:09 a.m. It read in pertinent part,Behavioral and other non-pharmacological approaches are used (unless contraindicated) to minimize or eradicate the need for medications, permit the lowest possible dose if indicated, and support efforts at gradual dose reduction.The clinical rationale for the use of psychotropic medication, or a change from one type of psychotropic to another, is documented in the medical record.Documentation must include that behavioral (non-pharmacological) interventions were attempted but not successful, and these interventions were deemed clinically contraindicated.Alternatively, documentation from a physician must describe that alternative treatments are clinically contraindicated and the rationale for this conclusion.Psychotropic medications are not prescribed or administered on a PRN basis unless the medication is necessary to treat a diagnosed specific condition that is documented in the clinical record. Psychotropic medications may be used on a PRN basis in certain situations, for example,while the dose is being adjusted; to address acute or intermittent symptoms; or in an emergency. II. Resident #1A. Resident statusResident #1, age [AGE], was admitted on [DATE]. According to the [DATE] computerized physician orders (CPO), diagnoses included post traumatic stress disorder (PTSD), anxiety and depression. The [DATE] minimum data set (MDS) assessment documented the resident was cognitively intact with a brief interview for mental status (BIMS) score of 15 out of 15. The MDS assessment indicated the resident did not exhibit any behaviors.B. Resident interviewResident #1 was interviewed on [DATE] at 8:53 a.m. Resident #1 said she used to have a therapist that would she her at the facility but the therapist did not come to the building anymore. Resident #1 said it had been a few months and the facility had not helped her make arrangements to find a new therapist or set up telemedicine (a virtual physician visit) so she could talk to a therapist on her tablet. Resident #1 said the medical director (MD) managed her psychotropic medications, not a psychiatrist. She said she did not know what psychotropic medications she took and she was not aware she could ask the staff when they were passing medications to her or ask about medications in her quarterly care conference meetings. C. Record reviewThe psychosocial care plan, revised [DATE], revealed Resident #1 took psychotropic medications related to depression, anxiety and PTSD. Interventions, revised [DATE], included monitoring her depression screen scores for indication of worsening signs/symptoms of depression, offering her non-pharmacological behavior interventions, such as calm approach, positive reassurance, one-on-one, quiet environment, offering of fluids/snacks, diversion activities, re-orientation, and re-direction. Review of Resident #1's [DATE] CPO revealed the following physician's orders:Offer non-pharmacological behavior interventions for any behaviors noted. Non-pharmacological interventions that are effective include calm approach, positive reassurance, one-on-one, quiet environment, offering of fluids/snacks, diversion activities, re-orientation, and re-direction, ordered on [DATE].-The physician's order failed to identify which non-pharmological interventions should be attempted for specific behaviors Buspirone (antianxiety medication) 10 milligrams (mg). Give two tablets by mouth three times a day, ordered on [DATE].Valium (a (continued on next page)

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	065399	A. Building B. Wing	04/22/2026

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F 0605 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	benzodiazepine used to treat anxiety) 5 mg. Give one tablet by mouth at bedtime, ordered on [DATE].Monitor behaviors for buspirone. Behaviors: panic with crying outbursts, ordered on [DATE].Monitor behaviors for Lexapro (an antidepressant medication). Behaviors: loss of appetite and fidgeting,ordered on [DATE].Duloxetine (an antidepressant medication) 30 mg. Give one tablet by mouth one time a day for behavior monitoring target behavior agitation/outbursts, ordered on [DATE].Lexapro (an antidepressant medication) 10 mg. Give one tablet by mouth one time a day for anxiety, ordered on [DATE].Monitor behaviors for duloxetine (an antidepressant medication). Behaviors: agitation as evidenced by outbursts, ordered on [DATE].-The [DATE] CPO failed to reveal any mental health or psychologically identified diagnoses for Resident #1's buspirone, valium, or duloxetine. Resident #1's Level II preadmission screening and resident review (PASRR) evaluation for mental illness and/or intellectual disabilities, dated [DATE], revealed Resident #1 had a history of self harm, suicidal thoughts, mood swings, loss of interest in activities, and low energy. The resident expressed during the evaluation that she enjoyed puzzles, games and painting. Specialized services recommended to ensure Resident #1's stability included developing therapeutic interventions to help her understand the source of her mood swings, developing coping skills to manage mood, psychiatric case consulting (psychiatrist oversight) to ensure symptoms were maximally managed by medications and to determine if another dosage would be beneficial, and increased socialization and participation in activities. -The resident's specific behaviors and non-pharmological interests identified in the Level II PASRR were not incorporated in Resident #1's behavior monitoring physician's orders or the resident's care plan (see physician's orders and care plan above).A review of psychotropic medication review meeting minutes revealed the last time Resident #1's medications were reviewed was in the meeting on [DATE]. Review of Resident #1's electronic medical record (EMR), from [DATE] to [DATE], failed to reveal any documented behaviors exhibited by the resident. -Review of Resident #1's EMR did not reveal documentation of a physician's rationale to justify the continued use of the resident's psychotropic medications, despite there being no documentation to indicate the resident was exhibiting behaviors. III. Resident #41A. Resident statusResident #41, age [AGE], was admitted on [DATE]. According to the [DATE] CPO, diagnoses included schizoaffective disorder, dementia, anxiety and depression. The [DATE] MDS assessment documented the resident was unable to participate in the BIMS assessment. A staff assessment for mental status revealed the resident had short term memory loss and severely impaired decision-making abilities. The MDS assessment indicated the resident did not exhibit hallucinations or delusions and did not have physically or verbally abusive behaviors.B. Record reviewThe psychosocial care plan, revised [DATE], revealed Resident #41 had diagnoses of schizophrenia, depression and insomnia. Interventions, revised [DATE], included monitoring her depression screen scores for indication of worsening signs/symptoms of depression, offering her non-pharmacological behavior interventions: offering of fluids/snacks, toileting, removing her from overstimulation, one-on-one, repositioning, and re-approaching at a later time.The mood care plan, revised [DATE], revealed Resident #41 had behaviors of yelling out random things or calling out to her husband. She had increased sadness, calling her husband's phone, and screaming at staff when they were trying to calm her down. Interventions, initiated [DATE], included monitoring for behaviors of screaming out at staff, allowing the resident time to call her husband and allowing her to express her emotions and thoughts.Review of Resident #41's [DATE] CPO revealed the following physician's orders:Offer non-pharmacological behavior interventions for any behaviors noted. Non-pharmacological interventions that are effective include calm approach, positive reassurance, one on one, quiet environment, offering of fluids/snacks, diversion activities, re-orientation, and re-direction-ordered on [DATE].-The physician's order failed to identify which non-pharmological interventions should be attempted for specific behaviors.Monitor behaviors for Lexapro. Behaviors: screaming at staff, ordered on [DATE].Olanzapine (an antipsychotic medication) 20 mg. Give one tablet by mouth two times a day for schizophrenia, ordered on [DATE].Monitor behaviors for olanzapine. Behaviors: hallucinations, kicking, yelling, ordered on (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	04/22/2026

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

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F 0605 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	[DATE].Lexapro 20 mg. Give one tablet by mouth in the morning for depression, ordered on [DATE].Resident #41's Level II PASRR evaluation for mental illness and/or intellectual disabilities, dated [DATE], revealed Resident #41 had a history of auditory hallucinations to include frequently hearing the devil inside of her head. The resident expressed during the evaluation that praying to the rosary calmed and soothed her. She had a family history of a schizophrenic father who committed suicide and multiple other suicides in her family along with mental illness. Resident #41 had at least two psychiatric hospitalizations for medication management. Specialized services recommended to ensure Resident #41's had psychiatric medication management (psychiatrist to manage medications). -The resident's specific behaviors and non-pharmological interests identified in the Level II PASRR were not incorporated in Resident #41's behavior monitoring physician's orders or the resident's care plan (see physician's orders and care plan above).A review of psychotropic medication review meeting minutes revealed the last time Resident #41's medications were reviewed was in the meeting on [DATE]. Review of Resident #41's EMR, from [DATE] to [DATE], revealed:A social services assessment note, dated [DATE], documented the resident was taking Lexapro for screaming at staff and olanzapine for hallucinations.-The social services assessment failed to indicate any non-pharmacological interventions utilized for the resident's behaviors. A long-term care evaluation note, dated [DATE], revealed Resident #41 was not experiencing unwanted behaviors and had been stable this month. A long-term care evaluation note, dated [DATE], revealed the resident was not experiencing unwanted behaviors and was moody sometimes with no negative behaviors.-Review of Resident #41's EMR did not reveal documentation of a physician's rationale to justify the continued use of the resident's psychotropic medications, despite there being no documentation to indicate the resident was exhibiting behaviors. IV. Resident #34A. Resident statusResident #34, age [AGE], was admitted on [DATE]. According to the [DATE] CPO, diagnoses included vascular dementia, anxiety and PTSD.The [DATE] MDS assessment documented the resident was unable to participate in the BIMS assessment. A staff assessment for mental status revealed the resident had short and long term memory loss and severely impaired decision-making abilities. The MDS assessment indicated the resident had behaviors of delusions, difficulty focusing her attention and disorganized thinking. C. Record reviewThe psychosocial care plan, revised [DATE], revealed Resident #34 had diagnoses of depression, dementia, anxiety, insomnia and PTSD. Interventions, initiated [DATE], included monitoring her depression screen scores for indication of worsening signs/symptoms of depression, offering her non-pharmacological behavior interventions: offering of fluids/snacks, toileting, removing from overstimulation, one-on-one, repositioning, and re-approaching at a later time. If the resident cried or became confused, she enjoyed going to her room and watching her favorite program or listening to 80's rock music.Review of Resident #34's [DATE] CPO revealed the following physician's orders:Abilify (an antipsychotic medication) 5 mg. Give one tablet by mouth at bedtime for depression, ordered on [DATE].Mirtazapine (an antidepressant medication) 15 mg. Give one tablet by mouth at bedtime for insomnia, ordered on [DATE].Sertraline (an antidepressant medication) 100 mg. Give one tablet by mouth in the morning for depression, ordered on [DATE].Offer non-pharmacological behavior interventions for any behaviors noted. Non-pharmacological interventions that are effective include calm approach, positive reassurance, one on one, quiet environment, offering of fluids/snacks, diversion activities, re-orientation, and re-direction, ordered on [DATE].-The physician's order failed to identify which non-pharmological interventions should be attempted for specific behaviors.Monitor behaviors for sertraline. Behaviors: verbal aggression towards staff, including foul language directed at staff, ordered on [DATE].Monitor behaviors for Abilify. Behaviors: verbalizing wanting to leave, including exit seeking, ordered on [DATE].Monitor behaviors for Abilify. Behaviors: tearfulness and crying, ordered on [DATE].Clonazepam (a benzodiazepine medication used to treat panic disorders) 0.5 mg. Give one tablet by mouth for anxiety, ordered on [DATE].Clonazepam 1 mg. Give one tablet by mouth at bedtime for insomnia, ordered on [DATE].Monitor behaviors for clonazepam. Behaviors: attempting to hit staff, ordered on [DATE].Review of Resident #34's EMR, from [DATE] to [DATE], (continued on next page)

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	065399	A. Building B. Wing	04/22/2026

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F 0605 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	revealed:A review of psychotropic medication review meeting minutes revealed the last time Resident #34's medications were reviewed was in the meeting on [DATE]. A long-term care evaluation note, dated [DATE], revealed Resident #34's mood was pleasant with no unwanted behaviors witnessed.A long-term care evaluation note, dated [DATE], revealed the resident's mood was pleasant with no unwanted behaviors witnessed.An alert note, dated [DATE], revealed Resident #34 was being tested for a urinary tract infection. She was tearful, agitated, and would become angry with staff. The resident was upset and asked to call her daughter. -Review of Resident #34's EMR did not reveal documentation of a physician's rationale to justify the continued use of the resident's psychotropic medications despite there being no documentation to indicate the resident was exhibiting behaviors. V. Resident #22A. Resident statusResident #22, age [AGE], was admitted on [DATE] and died on [DATE]. According to the [DATE] CPO, diagnoses included dementia and depression.The [DATE] MDS assessment documented the resident was severely cognitively impaired with a BIMS score of six out of 15. The MDS assessment indicated the resident did not exhibit hallucinations or delusions and did not have physically or verbally abusive behaviors.B. Record reviewThe psychosocial care plan, revised [DATE], revealed Resident #22 had impaired psychiatric and mood status related to an introduction to a skilled nursing facility, with new people and routines. Interventions, revised [DATE], included assisting the resident to cope by discussing possible solutions to conflict, encouraging the resident to to ask questions when concerned with his medical condition to reduce anxiety, encouraging participation from the resident to make his own decisions, providing him with quality listening time and encouraging expressions of feelings, and monitoring the resident for the following behaviors for haloperidol: swinging at staff, aggression toward staff, and agitation. Review of Resident #22's [DATE] CPO revealed the following physician's orders:Lexapro 10 mg. Give one tablet by mouth at bedtime for depression, ordered on [DATE].Monitor behaviors for Lexapro. Behaviors: lack of interest in day-to-day activities, ordered on [DATE].Monitor behaviors for Seroquel (an antipsychotic medication). Behaviors: aggressive behavior towards staff, failure to follow the plan of care, refusal to wear his oxygen or use his wheelchair, ordered on [DATE].Haloperidol injectable solution 5 mg. Inject 5 mg every six hours PRN for swinging at staff and agitation, ordered on [DATE].-The physician's order did not have a diagnosed specific condition listed in the order, only the behaviors associated with administering the medication.Seroquel 25 mg. Give one tablet by mouth three times a day for dementia with behaviors, ordered on [DATE] and discontinued on [DATE].Seroquel 25 mg. Give 50 mg (two tablets) by mouth three times a day for dementia with behaviors, ordered on [DATE] and discontinued on [DATE].Monitor behaviors for haloperidol. Behaviors: swinging at staff, aggression toward staff, and agitation two times a day until [DATE], ordered on [DATE].Offer non-pharmacological behavior interventions for any behaviors noted. Non-pharmacological interventions that are effective include calm approach, positive reassurance, one on one, quiet environment, offering of fluids/snacks, diversion activities, re-orientation, and re-direction, ordered on [DATE].-The order for non-pharmacological interventions to use for behaviors was not initiated until [DATE], despite Resident #22 being on psychotropic medications (including PRN haloperidol) since [DATE]. Review of Resident #22's EMR, from [DATE] to [DATE] revealed the following:The medication administration records (MAR), from [DATE] to [DATE], revealed that Resident #22 was provided with a PRN haloperidol injectable solution of 5 mg on [DATE], [DATE], [DATE], [DATE] and [DATE]. A behavior note, dated [DATE], revealed that Resident #22 was walking down the hallway without his oxygen on and he was not using his wheelchair. He attempted to swing his arms at staff when they attempted to get him to wear his oxygen. The resident did agree to sit in his wheelchair and allowed the staff to take him to the dining room and put his oxygen on him. An order administration note, dated [DATE], revealed the resident was given a haloperidol injectable solution of 5 mg.-Prior to the administration of the PRN haloperidol, there were no attempted non-pharmacological interventions documented.An order administration note, dated [DATE], revealed Resident #22 was given a haloperidol injectable solution of 5 mg.-The EMR failed to reveal (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	04/22/2026

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F 0605 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	documented behaviors and/or attempted non-pharmacological interventions prior to the administration of the PRN haloperidol on [DATE].An incident note, dated [DATE] at 1:08 p.m., revealed Resident #22 was attempting to urinate in the common area. Staff were able to stop the resident. An order note, dated [DATE] at 5:06 p.m., revealed that the resident was attempting to ambulate and refused to sit back in his wheelchair but allowed staff to sit him down in a regular chair. He continued to be restless, trying to get up and the staff encouraging him to sit down was ineffective. An order administration note, dated [DATE] at 5:10 p.m., revealed he was given a haloperidol injectable solution of 5 mg. -Prior to the administration of the PRN haloperidol, no attempted non-pharmacological interventions were documented other than encouragement to sit down, despite a physician's order being in place as of [DATE] to offer the resident a calm approach, positive reassurance, one-on-one, quiet environment, offering of fluids/snacks, diversion activities, re-orientation, and re-direction (see physician's orders above).An order administration note, dated [DATE] at 9:56 a.m., revealed Resident #22 was attempting to walk and refusing his wheelchair. He began to yell at the staff and would grab the staff by the arms and waist when they attempted to redirect him. The resident received a haloperidol injectable solution of 5 mg.-Prior to the administration of the PRN haloperidol, no attempted non-pharmacological interventions were documented other than redirection, but the note did not specify what redirection was attempted or why the other interventions were not attempted or effective.An order administration note, dated [DATE] at 11:01 a.m., revealed the resident refused assistance to his wheelchair and was observed swinging at staff and trying to rip the shelf off of the nurses' medication cart. The resident received a haloperidol injectable solution of 5 mg.-Prior to the administration of the PRN haloperidol, no attempted non-pharmacological interventions were documented. A behavior note, dated [DATE], revealed Resident #22 was sitting in his chair in the common area and would not allow the staff to put his oxygen on and was swinging at staff. The resident received a haloperidol injectable solution of 5 mg.-Prior to the administration of the PRN haloperidol, no attempted non-pharmacological interventions were documented. VI. Staff interviewsCertified nurse aide (CNA) #3 was interviewed on [DATE] at 1:31 p.m. CNA #3 said the CNAs looked for the resident-specific behaviors in the care plan and by watching the residents. CNA #3 said if there were changes in a resident's behaviors or non-pharmacological interventions, the nurses would relay this information to the CNAs verbally. CNA #3 said Resident #1 had behaviors of raising her voice when she felt passionately about something she was talking about. She said Resident #1 did not have many behaviors and enjoyed painting when she was upset. CNA #3 said that Resident #41 would chitter her teeth when mad but that was her only behavior. She said putting on music in her room or calling her husband were effective when she was upset. CNA #3 said that Resident #34 got overwhelmed in highly stimulating environments and sometimes refused to allow the staff to provide care to her, but she was unaware of any interventions that worked for her. Licensed practical nurse (LPN) #3 was interviewed on [DATE] at 3:06 p.m. LPN #3 said that the resident-specific behaviors were in the CPOs for the nurses. LPN #3 said if a resident displayed a behavior, the nurse would document it on the MAR and then make a progress note regarding which interventions were used from the template list provided in the CPO. She said if a resident was taking a PRN psychotropic medication, the nurse would document in the progress notes what non-pharmacological intervention was tried and its effectiveness before the administration of the PRN.LPN #3 said that Resident #1 was generally happy without behaviors but sometimes would have crying outbursts. She said she was unaware of any-non pharmacological interventions for Resident #1. LPN #3 said that Resident #41 would sometimes scream out in her room that she wanted to go home but if the staff talked with her, she only really wanted to call her husband. She said the staff could also play her religious compact discs for her. LPN #3 said that Resident #34 got overwhelmed in highly stimulating environments but she was unaware of any interventions that worked for her. The social services director (SSD) and the social services clinical resource were interviewed together on [DATE] at 4:00 p.m. The social services clinical resource said the behavior (continued on next page)

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	065399	A. Building B. Wing	04/22/2026

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F 0605 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	monitoring in the residents' CPO was turned over to the director of nursing (DON) about two years ago and the SSD only provided the DON with resident-identified behaviors. The SSD said he had only been in his current position for a month and was still receiving training from the social services clinical resource. The social services clinical resource said the facility was currently seeking a new mental health care provider to provide therapeutic services for residents who required it and a provider who could also manage psychotropic medications. He said the current mental health care provider the facility had used refused to share any documentation of visits or recommendations to the facility, citing patient confidentiality. The DON was interviewed on [DATE] at 9:04 a.m. The DON said she took over the position of DON in January of 2026 and she had identified inconsistencies in the psychotropic management process. The DON said the purpose of the psychotropic medication meeting was to review behaviors, interventions, and medications; however, the facility had not had a meeting since she had started in [DATE]. She said since the SSD was new and was in housekeeping prior to his new position, she had been trying to identify behaviors and interventions for the residents to demonstrate the effectiveness and necessity of the medications. The DON said one of her challenges was that the medical director (MD),who managed the psychotropic medications, would not accept recommendations from her or any outside providers. The DON said the facility had had many transitions of staffing in the DON and the SSD positions but the facility did not have a system in place to ensure that there were no interruptions in the continuity of the psychotropic management process due to staffing. She said that the non-pharmacological interventions listed in the residents CPOs were generic and not resident-specific. The DON said she expected the staff to attempt a non-pharmacological intervention prior to the use of a PRN antipsychotic medication and document the effectiveness to justify the necessity of using the PRN medication. She said that every resident on a psychotropic medication should have a mental health or psychologically identified diagnosis attached to the medication. The DON said Resident #1 was taking buspirone for panic with crying outbursts, Lexapro for self isolation, loss of appetite and fidgeting and duloxetine for agitation evidenced by outbursts. She said she did not know what the resident was taking valium for. The DON said she could not determine when the staff marked that Resident #1 was having a crying outburst, self isolating, or showing a loss of appetite that it was related to her PTSD or depression versus being due to a behavior warranting psychoactive medications. The DON said Resident #41 was taking Lexapro for screaming out at staff and olanzapine for hallucinations/kicking yelling. The DON said that Resident #41 had advanced dementia and no longer would use her call light for help but instead yelled out in her room. The DON said she could not determine when the staff marked Resident #41 was yelling out which medication was associated due to both medications being indicated for yelling, nor could she determine if Resident #41 had been yelling out due to a behavior warranting psychoactive medications and not related to an unmet need. She said the staff did not know the difference between Resident #41 yelling out in her room for help because she did not know how to use her call light verses yelling out related to hallucinations. The DON said Resident #34 was taking sertraline for depression, Abilify for depression, clonazepam for anxiety and a second dose of clonazepam for insomnia. The DON said when staff marked that Resident #34 had displayed verbal aggression, the DON said she could not determine if it was due to a behavior warranting psychoactive medications and not instead related to an unmet need or a lack of staff understanding of how to address verbal aggression. The DON said without a training program on how to identify resident-specific behaviors and how to utilize behavior monitoring, she could not ensure that the staff understood how to tell the difference between behaviors of situational distress or unmet needs (crying, outbursts, anger) verses behaviors being properly managed by psychotropic medications. She said the information from the behavior monitoring was used to make decisions on increases or decreases of psychoactive medications and it was important that the information was accurate to prevent the utilization of psychoactive medications for staff convenience for undesirable behaviors. The DON said that the behaviors identified on the monitoring and interventions provided should be resident-specific and individualized.

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	065399	A. Building B. Wing	04/22/2026

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F 0742 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Provide the appropriate treatment and services to a resident who displays or is diagnosed with mental disorder or psychosocial adjustment difficulty, or who has a history of trauma and/or post-traumatic stress disorder. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on record review and interviews, the facility failed to ensure residents diagnosed with a mental disorder or psychosocial adjustment difficulty received appropriate treatment and services to attain the highest practicable mental and psychosocial wellbeing for three (#34, #1 and #5) of five residents out of 31 sample residents. Specifically, the facility failed to:-Ensure expressions of suicidal ideations were addressed in order to secure Resident #34's safety;-Ensure Resident #1, who had a history of trauma and suicidal ideations, was monitored for signs and symptoms of suicidal ideation; and, -Ensure individualized care approaches were provided and monitored with ongoing assessment for Resident #5 in order to meet the emotional and psychosocial needs of the resident.Findings include: I. Failed to monitor and address suicidal ideations for Resident #34 and Resident #1 A. Resident #34 1. Resident status Resident #34, age [AGE], was admitted on [DATE]. According to the April 2026 computerized physician orders (CPO), diagnoses included vascular dementia, anxiety, and post-traumatic stress disorder (PTSD). The 3/8/26 minimum data set (MDS) assessment documented the resident was unable to participate in the brief interview for mental status (BIMS) assessment. A staff assessment for mental status revealed the resident had short and long term memory loss and severely impaired decision-making abilities. 2. Record review The mood care plan, revised 8/7/24, revealed Resident #34 was at risk for alterations in her psycho-social well-being related to dementia, depression and PTSD. Interventions, initiated 7/13/23, included monitoring the resident for psycho-social changes. (self-isolation, decreased activity participation, feelings of no self-worth). -The care plan failed to identify the resident expressed suicidal statements or ideations (see below). -Review of Resident #34's April 2026 CPO failed to reveal behavior monitoring for suicidal statements or ideations (see below). Review of Resident #34's electronic medical record (EMR), from 12/1/25 to 4/21/26, revealed the following: A long-term care evaluation note, dated 12/2/25, revealed Resident #34 had chronic behaviors potentially causing harm to self or others. -The note did not explain the behaviors or what interventions were being used to address those behaviors. (continued on next page)

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	065399	A. Building B. Wing	04/22/2026

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F 0742 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	A depression screen, dated 12/9/25, revealed the resident indicated on the screen she had little interest or pleasure in doing things nearly everyday. She felt down, depressed or hopeless nearly everyday. She had difficulty with appetite, sleep and energy half or most of the time. A social services assessment note, dated 12/9/25, revealed Resident #34 had a history of suicidal ideations. -The note did not explain what interventions were in place to address Resident #34's suicidal ideations. A long-term care evaluation note, dated 1/2/26, revealed that the resident was tearful with disruptive and unwanted behaviors. The resident was withdrawn. -The note did not explain what interventions were in place to address Resident #34's tearful or withdrawn behaviors. A depression screen, dated 2/24/26, revealed Resident #34 indicated on the screen she had little interest or pleasure in doing things nearly everyday. She felt down, depressed or hopeless nearly everyday. She had difficulty with appetite and energy half or most of the time. She felt bad about herself, felt like a failure, or felt she had let herself or her family down half or most of the time. A depression screen, dated 3/8/26, revealed the resident indicated on the screen she had little interest or pleasure in doing things nearly everyday. She felt down, depressed or hopeless nearly everyday. She had difficulty with appetite and energy half or most of the time. She felt bad about herself, felt like a failure, or felt she had let herself or family down half or most of the time. -Review of Resident #34's EMR failed to reveal further follow-up documentation after each time the resident expressed depression in her depression screens. A long-term care evaluation note, dated 4/2/26, revealed that Resident #34 was anxious with disruptive and unwanted behaviors. The resident was withdrawn. -The note did not explain what interventions were in place to address Resident #34's anxious or withdrawn behaviors. A behavior note, dated 4/15/26, revealed the resident expressed she was going to kill herself. The resident was kept in the common area and police and mental health assessors were contacted. -There was no documentation in the resident's EMR to indicate the facility put any interventions in place to keep the resident safe after the threat of suicide or monitored her for further signs and symptoms of suicidal ideations. B. Resident #1 1. Resident status Resident #1, age [AGE], was admitted on [DATE]. According to the April 2026 CPO, diagnoses included PTSD, anxiety and depression. (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	04/22/2026

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F 0742 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	The 3/19/26 MDS assessment documented the resident was cognitively intact with a BIMS score of 15 out of 15. The MDS assessment indicated the resident did not exhibit any behaviors. 2. Resident interview Resident #1 was interviewed on 4/20/26 at 8:53 a.m. Resident #1 said she used to have a therapist that would see her at the facility but the therapist did not come to the building anymore. Resident #1 said it had been a few months and the facility had not helped her make arrangements to find a new therapist or set up telemedicine so she could talk to a therapist on her tablet. She said it was hard for her to get over her past and she was going to therapy to help with that. She said as far as her PTSD, the facility had never asked her what her triggers were or what interventions would work for her. Resident #1 said there were several residents in the facility that had behaviors and were upsetting for her to be around. She said the facility instructed her to just avoid those residents. 3. Record review The depression care plan, revised 9/23/25, revealed Resident #1 was at risk for an alteration in psycho-social well-being related to anxiety, depression and a history of various traumatic life experiences. Interventions, revised 7/22/24, included monitoring the resident for psycho-social changes (self-isolation, decreased activity participation, feelings of no self-worth). The mood care plan, revised 2/24/26, revealed Resident #1 experienced panic attacks with crying outbursts and restlessness related to anxiety. Interventions, initiated 7/22/24, included offering her time to express her feelings and thoughts when she began to panic. -The care plan failed to identify a history of suicide attempts and ideations (see below). Review of Resident #1's April 2026 CPO failed to reveal behavior monitoring for suicidal attempts or ideations (see below). Review of Resident #1's EMR from 12/1/25 to 4/21/26 revealed: A depression screen, dated 12/27/25, revealed Resident #1 indicated on the screen she had little interest or pleasure in doing things and felt down, depressed or hopeless half or most of the time. She had difficulty with appetite and sleep nearly everyday. A depression screen, dated 3/19/26, revealed the resident indicated on the screen she felt down, depressed or hopeless and she felt bad about herself, felt like a failure, or felt she had let herself or family down half or most of the time. -Review of Resident #1's EMR failed to reveal further follow-up documentation after each time the resident expressed depression in her depression screens. Resident #1's Level II preadmission screening and resident review (PASRR) evaluation for mental illness and/or intellectual disabilities, dated 9/20/24, revealed that Resident #1 had a history of self harm, suicidal thoughts, mood swings, loss of interest in activities, and low energy. The resident expressed during the evaluation that she had suicidal thoughts but no plan. She reported believing (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	04/22/2026

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

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	065399	A. Building B. Wing	04/22/2026

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	065399	A. Building B. Wing	04/22/2026

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F 0742 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	BIMS score of 11 out of 15. 2. Observations and resident interview Resident #5 was interviewed on 4/19/26 at 3:45 p.m. in his room. Resident #5 said there was an incident a few weeks prior in which he touched a nurse's breast, but he was a changed man. He said he gave himself to the Lord. On 4/20/26 at 2:07 p.m. Resident #5 made six laps around the nurses' station while staring at a visitor. Resident #5 stared at the visitor and said You're really cute, I'm just reminiscing and Wow repeatedly. -Several staff members were near the nurses' station and failed to intervene. On 4/20/26 at 3:16 p.m. Resident #5 walked behind the certified nurse aide with medication authority (CNA-Med) #1, who stood at the hallway E and F medication cart. The resident looked her up and down and said Wow. CNA-Med #1 did not respond or acknowledge the resident. 3. Record review Review of Resident #5's EMR revealed the following progress notes: On 4/8/26 at 12:03 p.m. the DON documented Resident #5 was in the dining area listening to the music and watching the dancers. The DON documented she was in the dining room with the resident and he reached out and squeezed her breast. The resident immediately apologized. The DON documented she discussed the inappropriateness of this action with Resident #5. He apologized and said I won't do it again; I don't want to get into trouble. Review of Resident #5's comprehensive care plan, initiated 1/25/23, revealed the resident had behaviors related to occasional verbal/physical aggression toward others due to his diagnosis of Autism Disorder. He could become easily upset by situational stressors and he had a history of inappropriate sexual behaviors. Pertinent interventions, initiated 3/13/23, included approaching the resident in a calm manner to avoid frustration and behavior escalation; encouraging the resident to go to his room if he showed signs of agitation toward others; avoiding providing the resident access to provocative media; behavior monitoring for lorazepam, monitoring target behaviors, including physical aggression towards other residents; intervening and redirecting the resident when his behaviors began to escalate to prevent altercations with staff and residents; keeping the resident and other residents safe during episodes of behaviors and attempting to redirect; monitoring and documenting episodes of inappropriate behaviors; and, placing the resident on 15-minute behavior monitoring when behaviors escalated and if the behaviors continued during the 15-minute behavior monitoring, assign staff to provide one-to-one supervision until behaviors discontinued. -However, the care plan was not revised to reflect a person-centered intervention specific to Resident #5's documented sexual behavior toward the DON on 4/8/26 (see above). Review of Resident #5's electronic medical record (EMR) revealed the resident was placed on 15-minute behavior monitoring for 24 hours after the incident on 4/8/26. Further review of Resident #5's EMR revealed a behavioral agreement, dated 1/6/26, between the (continued on next page)

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	065399	A. Building B. Wing	04/22/2026

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	065399	A. Building B. Wing	04/22/2026

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F 0742 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	episodes and attempted to determine the cause of the behavior and offered positive conversation/activities to keep the resident engaged in a positive, nonsexual interaction. The DON said Resident #5 should have been placed on every 15-minute behavior monitoring and if his behaviors escalated or persisted, he should have been assigned a one-to-one sitter. She said the resident loved to walk outside and she should put that in his care plan. The DON was interviewed again on 4/21/26 at 4:52 p.m. The DON said Resident #5's behavioral health center did not allow the facility to view their notes due to patient confidentiality. She said if the resident spoke about a serious issue, such as suicidal ideation (SI) or homicidal ideation (HI), they would have communicated that specific finding with the facility via a note. The DON was interviewed a third time on 4/22/26 at 1:15 p.m. The DON said her nursing staff did not know what person-centered interventions for Resident #5 were, and the interventions that were in place were ineffective. She said she discussed with someone else earlier in the day about getting the CNAs involved in the care plan process.

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	065399	A. Building B. Wing	04/22/2026

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F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Provide and implement an infection prevention and control program. Based on observations, record review and interviews, the facility failed to maintain an infection control program designed to provide a safe, sanitary and comfortable environment to help prevent the possible development and transmission of infectious diseases on two of four hallways.Specifically, the facility failed to:-Ensure hand hygiene was performed appropriately when incontinence care was provided to Resident #2; -Ensure the vital signs equipment was disinfected between residents; and, -Ensure blood sugar glucometers were disinfected appropriately between residents.Findings include:I. Failed to ensure hand hygiene was performed appropriately when incontinence care was provided to Resident #2A. Facility policy and procedureThe Handwashing/Hand Hygiene policy, dated December 2025, was provided by the nursing home administrator (NHA) on 4/22/26 at 10:25 a.m. It read in pertinent part, Hand hygiene is the primary means for preventing healthcare-associated infections (HAIs) and the transmission of multidrug-resistant organisms (MDROs). Hand hygiene is indicated: before touching a resident; before preparing or handling food, medications or parenteral solutions; before clean or aseptic (sterile) procedures; before moving from work on a soiled body site to a clean body site on the same resident; after exposure to blood, body fluids, excretions or contaminated surfaces; after touching a resident; after touching the resident's environment or belongings; after glove removal; and, whenever the hands are visibly soiled. Use an alcohol-based hand rub (ABHR) containing at least 60 percent (%) alcohol for most clinical situations. Unless the hands are visibly soiled, ABHR is the preferred method of hand hygiene in clinical situations because it is more effective at killing germs, faster to use and less irritating to the skin than soap and water. Wash hands with soap and water: when the hands are visibly soiled with blood or body fluids; before eating and after using the restroom; after contact with a resident with infectious diarrhea including, but not limited to, infections caused by norovirus, salmonella, shigella and clostridium difficile (c-diff); and, during suspected or confirmed outbreaks of norovirus or c. difficile.B. ObservationOn 4/20/26 at 12:37 p.m. certified nurse aide (CNA) #1 responded to Resident #2's call light. The resident said he wanted to be changed and put in bed. CNA #1 said she needed to grab a second CNA and she would be right back.At 12:41 p.m. CNA #1 returned with certified nurse aide with medication authority (CNA-Med) #1 and a hoyer lift (mechanical lift). CNA #1 and CNA-Med #1 donned a gown and gloves as appropriate because the resident was on enhanced barrier precautions (EBP). Resident #2 was turned toward CNA-Med #1 when CNA #1 began to clean the resident's buttocks. CNA #1 stopped cleaning the resident's buttocks, walked away from the resident, and without changing her gloves, opened the top drawer of the resident's vanity and removed a cleansing spray and wipes.-CNA #1 failed to change gloves and perform hand hygiene after providing incontinence care and before opening the resident's vanity drawer to obtain the cleansing spray and wipes.Resident #2's son entered the room during incontinence care and noticed the nurses did not have the barrier cream readily available. With his bare hands, Resident #2's son opened the same drawer CNA #1 had opened previously with soiled gloves and removed the barrier cream.Without changing her gloves or performing hand hygiene, CNA #1 took the container of barrier cream from the resident's son, opened the container, used her gloved hand to scoop the cream out of the container and applied the cream to the resident's bottom.-CNA #1 failed to change gloves and perform hand hygiene after providing incontinence care and prior to reaching into the container of barrier cream with her soiled gloves.After the incontinence care was completed, CNA-Med #1 assisted Resident #2 to roll onto his back and returned the incontinence supplies, including the container of barrier cream, to the top drawer of the resident's vanity.-CNA-Med #1 failed to remove her gloves and perform hand hygiene after providing incontinence care and prior to replacing the barrier cream in the resident's vanity.Before they left Resident #2's room, CNA #1 and CNA-Med #1 doffed their gowns and gloves appropriately and performed hand hygiene with soap and water.C. Staff interviewsCNA #1 and CNA-Med #1 were interviewed together on 4/20/26 at 1:00 p.m. CNA #1 said she knew that it was wrong to use soiled gloves to touch the resident's environment and (continued on next page)

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	065399	A. Building B. Wing	04/22/2026

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	065399	A. Building B. Wing	04/22/2026

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F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	measured Resident #2's blood glucose level, CNA-Med #1 opened the Microdot minute wipes, removed one wipe and wiped the front, back and side surfaces of the glucometer for ten seconds. The surface of the glucometer was not wet or shiny looking when CNA-Med #1 placed the glucometer in a basket.-CNA-Med #1 failed to doff (remove) her soiled gloves and don clean gloves prior to disinfecting the glucometer.-CNA-Med #1 failed to follow the chemical dwell time to properly disinfect the glucometer (see professional reference above).CNA-Med #1 returned to the hallways E and F medication cart and documented Resident #2's blood glucose level before she continued administering medications to other residents. C. Staff interviewsCNA-Med #1 was interviewed on 4/21/26 at 11:00 a.m. CNA-Med #1 said the glucometer she used to measure Resident #2's blood glucose level was a shared glucometer. She said she thought the dwell time for the Microdot minute wipes was five minutes, and it was important the chemical dwell times were followed in order to remove all of the germs from the device and get the device clean. CNA-Med #1 said in hallways E and F there were six residents who shared the glucometer on a daily basis and one resident who used the glucometer on a monthly basis.Licensed practical nurse (LPN) #1 was interviewed on 4/21/26 at 11:20 a.m. LPN #1 said after she would collect a resident's blood sugar level, she would use Caviwipes to clean the glucometer. She said the Caviwipes were kept at the nurses' station. She said she did not know the chemical dwell time for the wipes, but she would find out. At the nurses' station, LPN #1 showed the wipes she used to clean the glucometer, however she showed the Super Sani Cloth germicidal wipes. She said the chemical dwell time for the wipes was two minutes, and it was important to follow the dwell time in order to kill bacteria/viruses and prevent the transmission of bloodborne illnesses.CNA #1 was interviewed on 4/21/26 at 12:25 p.m. CNA #1 said after she collected a resident's vital signs, she sanitized the vital signs equipment. She said she wore gloves and used alcohol wipes to ensure the blood pressure cuff and the vital signs equipment tower was sanitized. CNA #1 said the alcohol wipes were kept at the nurses' station and she did not know the chemical dwell time. She said the facility had provided education on infection control practices, but she was unable to recall the education she received. LPN #3 was interviewed on 4/21/26 at 12:29 p.m. LPN #3 said she typically worked as the minimum data set (MDS) coordinator, but she was working as the charge nurse today (4/21/26). She said if she had collected the residents' vital signs she would have disinfected the vital signs equipment on the way into the resident's room, but not always on the way out of the room - it depended on who the resident was. LPN #3 said she used the Caviwipes to disinfect the vital signs equipment, but said she was unable to locate the wipes. She said the facility usually kept the wipes at the nurses' station. LPN #3 said she did not know the chemical dwell time of the Caviwipes.LPN #3 said it was important to follow the chemical's dwell time because not following the dwell time affected the cleanliness of the equipment. She said not following the dwell time could cause a risk of infection transmission between the residents. LPN #3 said she was not sure when the last time she received education on infection control practices was because she did not participate in the all-staff meetings as the MDS coordinator.LPN #1 was interviewed again on 4/21/26 at 12:55 p.m. LPN #1 said the glucometer was stored in a basket in the top drawer of the medication cart, and there were three residents who shared the glucometer in hallways A and B.The DON was interviewed on 4/21/26 at 2:04 p.m. The DON said the glucometers could be shared between residents if they were sanitized appropriately after every use. She said there was a checklist at the nurses' station to ensure the glucometers were cleaned daily. She said the glucometers should be cleaned after each resident and they were stored in a basket in the locked top drawer of the medication carts. The DON said on hallways A and B, there were three residents who shared a glucometer and each used the device three times per day. She said on hallways E and F, there were six residents who used the device daily and one resident who used it monthly. The DON said CNA-Med #1 should have cleaned the glucometer for the appropriate amount of time and then allowed it to dry appropriately before it was returned to the basket. She said the glucometer should not be returned to the basket until it was fully dry.The DON said the facility typically used the Assure Platinum glucometers but they ran out of the (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	04/22/2026

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

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F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	glucometer test strips on Monday 4/20/26 and the replacement strips would not arrive until Wednesday 4/22/26. She said they purchased the Leader True Metrix glucometer to have in the meantime.The DON was interviewed again on 4/21/26 at 2:48 p.m. The DON said she called the True Metrix glucometer's manufacturer and they told her the Super Sani-Cloth wipes were recommended for disinfection. She said she threw the Microdot wipes away and placed the Super Sani-Cloth wipes on the medication carts for nursing staff to use. The DON said the manufacturer's recommendations reported that other types of sanitizer wipes had not been tested on the device.The DON was interviewed a third time on 4/22/26 at 1:15 p.m. The DON said when the nursing staff was measuring vital signs, the vital signs equipment should be disinfected with Super Sani-Cloth wipes between each resident. She said she thought the chemical dwell time for the wipes was three minutes and it was important to follow the chemical dwell time for infection control and to prevent cross-contamination.

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	065399	A. Building B. Wing	04/22/2026

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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 0582 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Give residents notice of Medicaid/Medicare coverage and potential liability for services not covered. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on interviews on record review, the facility failed to ensure two (#35 and #41) of three residents reviewed for Medicare or Medicaid covered services out of 31 sample residents were notified of changes in their services covered, including their financial responsibility and their appeal rights. Specifically, the facility failed to: -Ensure Resident #35 was provided notification that his Medicare Part A covered skilled services were ending within the required time parameter; -Ensure Resident #41's representative was provided written notification of the Medicare Notice of Non-Coverage (NOMNC) letter when Resident #41's Medicare Part A covered skilled services were ending; and,-Ensure Resident #41's representative was notified of the right to appeal when the resident's Medicare Part A covered skilled services were ending.Findings include: I. Resident #35 A. Resident status Resident #35, age [AGE], was admitted on [DATE]. According to the April 2026 computerized physician orders (CPO), diagnoses included chronic respiratory failure with hypoxia, chronic obstructive pulmonary disease (COPD - a progressive lung disease restricting airflow), schizophrenia (a chronic severe brain disorder characterized by hallucinations and delusions), dementia and anxiety. The 4/13/26 minimum data set (MDS) assessment revealed the resident was cognitively intact with a brief interview for mental status (BIMS) score of 13 out of 15. B. Record review Review of Resident #35's electronic medical record (EMR) revealed Resident #35 was discharged from Medicare Part A skilled therapy services on 12/12/25. The NOMNC for Resident #35 identified the resident's skilled services were to end on 12/12/25. Resident #35 signed the NOMNC on 12/12/25, the same day the skilled services were ending.- A review of Resident #35's EMR revealed no documentation to indicate that Resident #35 was given at least a two-day notice that his Medicare Part A skilled services would be ending on 12/12/25. II. Resident #41 A. Resident status Resident #41, age [AGE], was admitted on [DATE]. According to the April 2026 CPO, diagnoses included schizophrenia, COPD, dementia with anxiety and heart disease. The 3/14/26 MDS assessment revealed a BIMS assessment was not conducted because the resident was rarely or never understood. According to the staff assessment for mental status, the resident had short and long-term memory problems and her cognitive skills for daily decision making were severely impaired. B. Record review Review of Resident #41's EMR revealed Resident #41 was discharged from Medicare Part A skilled therapy services on 11/28/25. The NOMNC notice revealed verbal notification was provided to Resident #41's representative on 11/25/25. The resident continued to live in the facility. -However, a review of Resident #41's EMR revealed no documentation to indicate that Resident #41's representative was provided with a written notice that Resident #41's Medicare Part A skilled therapy services were ending, given the estimated cost of services the resident would incur if the representative chose to pay out of pocket to continue skilled therapy services, the reason why the Medicare Part A skilled therapy services were ending and/or the information the representative needed to appeal the decision, if desired.III. Staff interviewsThe NHA was interviewed on 4/22/26 at 1:16 p.m. The NHA said the social services director (SSD) was responsible for notifying the resident or the resident's representative when Medicare Part A skilled services would be ending. The NHA said the notification was to allow 48 hours prior to the end of services. The NHA said the SSD needed to educate the resident or the resident's representative of their right to appeal the decision if they wanted to remain on Medicare Part A skilled services longer. The NHA said a signed copy of the NOMNC letter was supposed to be provided to the resident or the resident's representative. The NHA said if the notice was given over the phone, there should be documentation on the NOMNC letter of the verbal notification and documentation to indicate appeal rights were explained to the resident or the resident's representative. The NHA said the SSD was new to the position. The NHA said Resident #35 was at the facility with a different SSD who no longer worked at the facility. The NHA said he did not know why the resident was provided notice the same day the resident's skilled services ended. The NHA (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	04/22/2026

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Rio Grande Rehabilitation and Healthcare Center	39 Calle Miller LA Jara, CO 81140

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F 0582 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	said Resident #41's Medicare Part A skilled services coverage ended when a different SSD worked at the facility. The NHA said he did not know why there was no documentation that the resident's right to appeal was explained and that a copy of the NOMNC letter was provided to the resident's representative.

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	065399	A. Building B. Wing	04/22/2026

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F 0604 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure that each resident is free from the use of physical restraints, unless needed for medical treatment. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observations, record review and interviews, the facility failed to ensure residents were free from physical restraints for two (#3 and #7) of two residents out of 31 sample residents. Specifically, for Resident #3 and Resident #7, the facility failed to:-Ensure that the resident's representatives were informed of the potential risks and benefits of a wanderguard (a wearable device that helps prevent residents from eloping from the facility);-Ensure the wanderguard was the least restrictive approach for the residents;,-Ensure the residents' wanderguards were monitored for continued use; and,-Develop and implement interventions for reducing the restraint.Findings include:I. Facility policy and procedureThe Tab Alarms, Bed Alarms, Wanderguard System policy and procedure, undated, was provided by the nursing home administrator (NHA) on 4/22/26 at 6:38 p.m. It read in pertinent part, The wanderguard will be used for residents at risk for elopement. For each resident to reach his/her highest practicable well being in an environment that prohibits the use of restraints for discipline or convenience. A nursing assessment of each resident must be done on admission and change in status to evaluate if he/she is at risk for falls or elopement. A plan of care must be formulated with the interdisciplinary team (IDT - nursing, physical therapy, occupational therapy, dietary, activities, social worker, and resident/family), to determine the need for tab or bed alarms or a wanderguard bracelet and documented in the care plan. The wanderguard bracelet will be applied to the resident's wrist or ankle and not removed until replacement is needed. The wanderguard bracelets are checked daily on the night shifts by the supervisor and are documented in the treatment book on the units.II. Resident #3A. Resident statusResident #3, age [AGE], was admitted on [DATE]. According to the April 2026 computerized physician orders (CPO), diagnoses included chronic obstructive pulmonary disease (COPD), asthma, muscle weakness and dementia with behavioral disturbance. The 3/24/26 minimum data set (MDS) assessment revealed Resident #3 had moderate impaired cognitive impairment with a brief interview for mental status (BIMS) score of nine out of 15. The resident needed supervision or touching assistance with most of her activities of daily living (ADL). The assessment documented Resident #3 did not wander. The assessment documented Resident #3 used a wander/elopement alarm daily. B. ObservationsDuring a continuous observation on 4/20/26, beginning at 12:35 p.m. and ending at 3:05 p.m., the following was observed:At 12:35 p.m. Resident #3 came out of her room and wheeled herself into the common area. A wanderguard was observed on the resident's right ankle.At 12:40 p.m. Resident #3 left the common area and went back to her room.At 12:52 p.m. Resident #3 left her room and went back into the common roomAt 1:00 p.m. Resident #3 played a card game with other residents and the activities staff member in the common area. At 1:52 p.m. Resident #3 continued to play the card game. At approximately 2:30 p.m. Resident #3 went to her room. At approximately 2:45 p.m. Resident #3 went back to the common area. At 3:05 p.m. Resident #3 was playing table pong in the common area.Resident #3 displayed no attempts to exit-seek during the approximately three and a half hour continuous observation. C. Record reviewResident #3's elopement care plan, initiated 10/13/25, revealed the resident was at risk for elopement due to exit seeking, verbalizing leaving the facility and wandering. Interventions included applying a wanderguard, monitoring the placement and function of the wanderguard, periodically evaluating the wanderguard for continued need and promptly checking when the wanderguard alarm system went off to ensure Resident #3 was safe and remained in the facility. -However, the facility failed to document measures taken to systematically reduce or eliminate the need for the wanderguard (see below). An elopement evaluation, dated 10/13/25, revealed Resident #3 was a high elopement risk. The evaluation documented Resident #3 wandered in the facility, verbalized or exhibited exit-seeking behavior and was capable of leaving the facility. However, the evaluation documented the resident did not have a history of elopement.-Review of Resident #3's electronic medical record (EMR) revealed no documentation to indicate additional (continued on next page)

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	065399	A. Building B. Wing	04/22/2026

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F 0604 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	elopement evaluations were completed for the resident.Review of Resident #3's April 2026 CPO revealed the following physician's orders:Place wanderguard related to exit-seeking behavior, ordered 10/13/25.Wander Guard: Ensure that wander guard is functioning properly every day, ordered 10/14/25.Wanderguard: Check for placement every shift, ordered 10/14/25.The nurse progress note, dated 10/12/25 at 7:04 p.m., documented Resident #3 pushed the front door of the facility open and said I am leaving this place, my brother is outside waiting for me. The nurse explained to the resident that her brother was not outside and that she would have to come back into the facility because that was where she lived. The resident was angry, but hesitantly came back into the facility. The order administration note, dated 10/12/25 at 9:35 p.m., documented Resident #3 opened thefront door and was stating that she wanted to leave with her sister-in-law, who was not in the facility. The resident was stating that the staff were trying to kill her. The resident was administered a dose of as needed Haldol (antipsychotic medication used to treat acute agitation) which was effectiveThe nurse progress note, dated 10/13/25 at 12:11 p.m., documented a wanderguard bracelet was placed on the resident's right ankle and the director of nursing (DON) was aware.-However, review of Resident #3's EMR failed to reveal that the facility discussed the risks versus benefits of the wanderguard with the resident's representative or that consent was obtained from the representative for the placement of the wanderguard.The progress note, dated 10/13/25 at 3:58 p.m., documented Resident #3 had received Haldol last night (10/12/25) and had been sleeping all day. The resident would continue to be monitored.-The note did not indicate the reason the wanderguard was placed on the resident as she was not continuing to exit-seek after receiving Haldol the night before.A behavior note, dated 10/29/25 at 3:09 a.m., documented Resident #3 was saying I am not staying here! What are you trying to do to me? The note documented Resident #3 thought that staff members were trying to harm her. The note documented that she was given pain medication in case she was in pain. -However, the note did not indicate that Resident #3 was trying to leave the facility. A progress note, dated 11/4/25 at 1:05 p.m. documented the resident's wanderguard was replaced and the new one was placed on her left ankle. -However, the note did not document that the wanderguard was re-evaluated to determine if it was still appropriate and necessary for Resident #3.The behavior note, dated 11/13/25 at 1:57 p.m. documented the resident had increased anger, frequent episodes of talking to herself in frustration and was wandering the hallways with no goal in mind.-The note did not indicate that the resident was attempting to leave the facility.The physician's progress note, dated 11/20/25 at 1:28 p.m., documented Resident #3 had worsening behaviors of visual hallucinations and exit-seeking The resident's Seroquel (antipsychotic medication) was increased by the physician.-However, there was no documentation in the resident's EMR to indicate the resident had additional exit-seeking attempts between 10/12/25 and 11/20/25 (see above).The nurse progress note note, dated 11/24/25 at 4:30 p.m., documented Resident #3 was in the hallway stating that she was waiting for an employee to pick her up and he did not pick her up. The note documented Resident #3 stated she wanted to get the hell out of there and then went to her room and put herself to bed. -However, the note did not indicate Resident #3 tried to leave the facility.The long-term care evaluation note, dated 12/15/25 at 7:16 p.m., documented Resident #3 had chronic wandering behavior noted and wandered at night. The resident had a wander/elopement alarm in use.-However, the note did not indicate that the resident attempted to exit-seek and/or leave the facility. The long-term care evaluation note, dated 2/16/26 at 2:07 a.m., documented the resident had no unwanted behaviors witnessed and did not wander at night. The resident had a wander/elopement alarm in place due to a history of elopement.-However, there was no documentation to indicate the resident had attempted to leave the facility other than on 10/12/25 (see progress notes above). Review of Resident #3's EMR did not reveal any further exit-seeking behaviors or verbalization that Resident #3 tried to leave the building or talked about leaving the building from 11/24/25 to 4/21/26.-However, there was no documentation to indicate the facility had re-evaluated the resident between 11/24/25 to 4/21/26 to determine if the wanderguard was still appropriate and necessary for Resident #3. -Additionally, review of the resident's EMR failed (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	04/22/2026

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

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F 0604 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	to reveal documentation that a less restrictive method was offered or tried with the resident, prior to the wanderguard being implemented. III. Resident #7A. Resident statusResident #7, age [AGE], was admitted on [DATE]. According to the April 2026 CPO, diagnoses included dementia, muscle weakness, cardiac murmur and edema.The 2/25/26 MDS assessment revealed Resident #7 was unable to complete the BIMS assessment. The staff assessment for mental status documented Resident #7 had long-term memory problems, she was able to locate her own room, but her cognitive skills for daily decision-making were severely impaired. The assessment revealed Resident #7 needed partial to moderate assistance with most of her ADLs. The assessment documented Resident #7 did not wander. The assessment documented Resident #7 used a wander/elopement alarm daily. B. Resident's representative interviewResident #7's representative was interviewed on 4/20/26 at 10:26 a.m. The representative said she did not know what a wanderguard was. She said to her knowledge, Resident #7 did not have a wanderguard. She said Resident #7 did not wander and had not tried to leave the facility and did not have a history of trying to leave the facility. C. ObservationsDuring a continuous observation on 4/20/26, beginning at 12:45 p.m. and ending at 3:09 p.m., the following was observed:At 12:45 p.m. Resident #7 was sleeping in the dining room at her table. The table was empty in front of her and there were no employees in the dining room. The resident had a wanderguard on her ankle.At 1:06 p.m. Resident #7 walked from the dining room into the common area. The resident's pants were visibly soiled with a large brown stain on the back of her pants and the back of her shirt at the bottom. At 1:08 p.m. an unidentified activities staff member asked Resident #7 if she wanted to play cards. The social services clinical consultant noticed that Resident #7 needed to be changed and a certified nurse aide (CNA) took the resident to be changed in her room. At 1:50 p.m. Resident #7 was sitting in the common area with a new pair of pants on and a new shirt. At 2:39 p.m. Resident #7 stood and began to walk down the hallway to her room. At 2:40 p.m. an unidentified staff member redirected Resident #7 back to the common area to watch television. At 3:09 p.m. Resident #7 was sleeping in the common area on the couch.-Resident #7 displayed no attempts to exit-seek during the approximately two and a half hour continuous observation. D. Record reviewResident #7's elopement care plan, revised 12/10/24, documented Resident #7 was at high risk for elopement due to exit-seeking and wandering behaviors. Interventions included calmly redirecting and diverting the resident's attention, distracting the resident by offering activities, food, conversation, television and books, evaluating the need for a wanderguard, monitoring placement and functionality of the wanderguard and promptly checking when alarm system went off to ensure the resident was still safe in the facility. The elopement evaluation, dated 4/23/24, documented Resident #7 was a high risk for elopement. The evaluation documented Resident #7 was capable of leaving the facility, was not alert and oriented by three, wandered throughout the facility, verbalized or exhibited exit-seeking behavior and had a history of attempted or actual elopement. -However, review of Resident #7's EMR revealed no documentation to indicate the facility had re-evaluated the resident between 11/23/24 to 4/21/26 to determine if the wanderguard was still appropriate and necessary for the resident.Review of Resident #7's April 2026 CPO revealed the following physician's orders:Wander Guard: Ensure that the wander guard is functioning properly every day, ordered 4/23/24.Wanderguard: Check for placement every shift, ordered 4/23/24.-However, there was no physician's order to place the wanderguard.The behavior note, dated 11/18/25 at 3:59 p.m. documented Resident #7 had two episodes where staff found her in the wrong rooms going through the contents of the rooms, including food, and attempting to remove items from the rooms. The resident was not easily redirected on both occasions. The resident offered fluids and snacks but continued to state this is my room. The resident was taken to her own room and showed her belongings and then she calmed down.-However, the note did not indicate that the resident was attempting to leave the facility.The progress note, dated 12/4/25 at 5:51 p.m., documented Resident #7 was in another resident's room rummaging through the drawers. A CNA went and got Resident #7 and redirected her to her room.-However, the note did not indicate that the resident was attempting to leave the facility.The physician's progress note, dated 1/12/26 at 9:37 (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	04/22/2026

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
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F 0604 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	a.m., documented Resident #7 had advanced dementia with behaviors of wandering into other residents' rooms or not respecting personal boundaries.-However, the note did not indicate that the resident was attempting to leave the facility.The long-term care evaluation note, dated 2/9/26 at 11:50 p.m., documented Resident #7 had chronic wandering behaviors noted and wandered at night. The resident had a wander/elopement alarm in use related to elopement risk.-However, the note did not indicate that the resident attempted to exit-seek and/or leave the facility.The long-term care evaluation note, dated 4/9/26 at 10:03 p.m., documented the resident had no unwanted behaviors witnessed and wandered at night. The note indicated the resident did not have any restraints or alarms in place.-However, observations during the survey revealed the resident had a wanderguard.-Additionally, review of Resident #7's EMR revealed there was no documentation to indicate the resident had attempted to leave the facility.-Review of Resident #7's EMR failed to reveal that the facility discussed the risks versus benefits of the wanderguard with the resident's representative or that consent was obtained from the representative for the placement of the wanderguard.-Additionally, review of the resident's EMR failed to reveal documentation that a less restrictive method was offered or tried with the resident, prior to the wanderguard being implemented. IV. Staff interviewsCNA #3 was interviewed on 4/21/26 at 3:38 p.m. CNA #3 said she had only been working at the facility for a month. She said she was able to identify if a resident was an elopement risk if they were wearing a wanderguard. She said if she saw a resident trying to leave the building or wandering, she would try to redirect them by offering a snack or trying to give them something else to do. She said she had not seen Resident #3 try to leave the building. She said she had only seen Resident #3 go from her room to the dining room, but she said she was not that familiar with the resident. She said Resident #7 wandered into other residents' rooms. She said Resident #7 was redirectable. CNA #2 was interviewed on 4/21/26 at 4:00 p.m. CNA #2 said he was able to identify if a resident was an elopement risk because the resident would be wearing a wanderguard. He said he also would get reports from other CNAs and the charge nurses if a resident had a wanderguard. He said there was a place in the EMR where it would list if a resident was an elopement or wander risk. He said he did not think that it listed the interventions to be used if a resident exhibited those behaviors. He said that Resident #3 was very independent and would yell at people that no one else could see. He said he never saw Resident #3 try to leave the building or wander, other than down to her room and the common areas. He said Resident #7 would wander into other residents' rooms. He said she did not like male staff members so he tried his best to respect that boundary. Certified nurse aide with medication authority (CNA-Med) #1 was interviewed on 4/21/26 at 4:18 p.m. CNA-Med #1 said she identified residents who were wander risks and elopement risks because they wore wanderguards. She said staff kept a closer eye on residents who had wanderguards. She said the standard interventions that staff used were redirection, giving them a different activity, offering them snacks and toileting. She said she was unsure if the interventions were resident-specific. CNA-Med #1 said Resident #3 did not wander and was not an elopement risk. She said Resident #7 would try and go out the back door that was down her hall. She said she would also wander into other residents' rooms. She said Resident #7 used to be a nurse and staff thought that the reason why Resident #7 wandered at certain times was because she thought she was doing her nursing rounds. She said there were times when she would try and give Resident #7 nursing tasks and that helped distract her from wandering. CNA-Med #1 said she was unsure if that intervention was documented anywhere. She said it should be documented on the care plan. -However, the nursing intervention to offer the resident nursing tasks was not documented on Resident #7's care plan (see record review above). Licensed practical nurse (LPN) #3 was interviewed on 4/21/26 at 4:37 p.m. LPN #3 said there was a list of residents that wandered and were at risk for elopement at the nurses' station. She said the residents who were on that list had wanderguards. She said the residents were reassessed quarterly for their wanderguards. She said the care plans had the residents' interventions listed. She said that a wanderguard was not a restraint, it was an alert safety device. -However, there was no (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	04/22/2026

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

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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 0604 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	documentation in Resident #3 or Resident #7's EMRs to indicate the facility had reassessed the residents to see if their wanderguards continued to be appropriate and necessary for the residents (see record review above).Registered nurse (RN) #2 was interviewed on 4/22/26 at 10:33 a.m. RN #2 said residents were assessed for elopement on admission and if a resident tried to leave or started to talk about leaving, the facility would assess them for elopement risk. She said she thought that residents would get reassessed for elopement every three months. She said interventions for wandering and elopement were on the residents' care plans. She said she did not consider a wanderguard a restraint because it did not stop the resident from leaving,but it alerted the staff that the resident was trying to leave. The DON was interviewed on 4/22/26 at 11:20 a.m. The DON said the facility assessed a resident for a wanderguard with an elopement evaluation and by monitoring the resident's behaviors. She said residents were reassessed quarterly for the wanderguard. She said the assessments were done in the EMR by the charge nurse. The DON said that a wanderguard was a restraint because it limited the resident's ability to leave the facility. She said the risk versus benefits was not listed on the consent that was given to the resident's responsible party. She said interventions should be listed on the care plan for residents who wandered or eloped. She said when a resident tried to leave the building, she expected staff to approach the resident in a calm manner and use the listed interventions from the resident's care plan. She said she did not think that the facility documented the root cause or triggers of why a resident wandered or tried to elope. She said the facility needed to add what interventions were used when a resident wandered or tried to leave the facility. She said the interdisciplinary team (IDT) would determine what the best intervention (least restrictive) were for a resident. She said they made the determination as a group, based on observations and the resident's behaviors. She said it was documented in the IDT notes. She said the assessments for the wanderguards were reviewed quarterly during the IDT meeting. -However, there was no documentation in Resident #3 or Resident #7's EMRs to indicate the facility had reassessed the residents to see if their wanderguards continued to be appropriate and necessary for the residents (see record review above).The DON said she thought that Resident #7 was due for a re-evaluation of her wanderguard, but she thought the resident still required the wanderguard due to her wandering. She said Resident #3 was also due for a re-evaluation of her wanderguard. She said Resident #3 had not tried to leave the building during her (the DON's) time working for the facility. She said she thought Resident #3 would be a good candidate to have her wanderguard removed.

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	065399	A. Building B. Wing	04/22/2026

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F 0658 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure services provided by the nursing facility meet professional standards of quality. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on record review and interviews, the facility failed to ensure residents were provided services that met professional standards of quality for one (#5) of nine residents out of 31 sample residents. Specifically, the facility failed to ensure Resident #5, who was receiving an anticoagulant medication (blood thinner), received international normalized ratio (INR) blood draws (a blood test that measures how long it takes the blood to clot) per the physician's orders.Findings include:I. Professional referenceAccording to Shikdar, Sufana et al., International Normalized Ratio (INR): Assessment, Monitoring, and Clinical Implications, StatPearls Publishing, (2025), retrieved on 4/27/26 from www.ncbi.nlm.nih.gov/books/NBK507707/, The INR is the preferred parameter for monitoring patients taking vitamin K antagonists. This variable is also used to assess the risk of bleeding and to evaluate the coagulation (clotting) status of these patients. Individuals on oral anticoagulants must monitor their INR values to adjust doses of vitamin K antagonists. Patients are typically monitored every three to four weeks. INR monitoring is most commonly required for patients taking warfarin, a vitamin K antagonist. The warfarin dose is adjusted based on INR values to maintain the therapeutic range. The anticoagulant effect of warfarin, as indicated by an INR within the target range, also helps determine when to discontinue heparin therapy.II. Resident #5A. Resident statusResident #5, age less than 65, was admitted on [DATE]. According to the April 2026 computerized physician orders (CPO), diagnoses included the presence of a prosthetic heart valve, type 2 diabetes mellitus and long term use of anticoagulants.The 3/13/26 minimum data set (MDS) assessment revealed the resident was moderately cognitively impaired with a brief interview for mental status (BIMS) score of 11 out of 15. The MDS assessment indicated the resident was receiving anticoagulant medication.B. Record reviewReview of Resident #5's April 2026 CPO revealed the following physician's orders:Prothrombin time (PT - measures how many seconds it takes blood to clot) and INR, in the morning every four weeks on Monday, ordered 12/1/25.Warfarin sodium tablet 5 milligrams (mg), give one tablet by mouth in the evening for treating/preventing blood clots, ordered 10/8/25. Review of Resident #5's electronic medical record (EMR) revealed the following:Resident #5's PT/INR was measured at least every four weeks as ordered by the physician throughout 2025.For 2026, Resident #5's PT/INR was measured on 1/5/26, 2/12/26 and 4/21/26.-However, the facility failed to ensure Resident #5's PT/INR was measured in March 2026.III. Staff interviewsThe director of nursing (DON) was interviewed on 4/22/26 at 1:15 p.m. The DON said Resident #5's INR was not drawn in March 2026 because the facility had a new charge nurse, and she (the DON) did not follow up with the charge nurse on the PT/INR lab draws for the month of March 2026. She said administering warfarin without knowledge of the resident's coagulation status could cause bleeding or a change of condition. The DON said the nursing staff should follow the physician's orders.Pharmacist #1 was interviewed on 4/22/26 at 2:42 p.m. Pharmacist #1 said Resident #5's PT/INR should be measured, at a minimum, monthly. She said there were target parameters for the resident's INR specific to warfarin monitoring. Pharmacist #1 said it was important to monitor the resident's INR status closely because an abnormal INR test result could increase the risk of bleeding or cause excess clotting of the resident's blood.

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	04/22/2026

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

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F 0689 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure that a nursing home area is free from accident hazards and provides adequate supervision to prevent accidents. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observations, record review and interviews, the facility failed to provide supervision, assistance, services, and implement effective person-centered interventions to prevent falls for one (#34) of five residents reviewed for accidents/hazards out of 31 sample residents.Specifically, the facility failed to thoroughly assess Resident #34's falls to reduce individual risks and ineffective interventions.Findings include:I. Facility policy and procedureThe Fall- Clinical Protocol policy, revised March 2018, was provided by the nursing home administrator (NHA) on 4/22/26 at 10:09 a.m. It read in pertinent part,The staff and practitioner will review each resident's risk factors for falling and document in the medical record. Examples of risk factors for falling include lightheadedness or dizziness, multiple medications, musculoskeletal abnormalities, peripheral neuropathy, gait and balance disorders, cognitive impairment, weakness, environmental hazards, confusion, visual impairment, hypotension, and medical conditions affecting the central nervous system.After a first fall, the staff (and physician, if possible) should watch the individual rise from a chair without using his or her arms, walk several paces, and return to sitting. If the individual has no difficulty or unsteadiness, additional evaluation may not be needed. If the individual has difficulty or is unsteady in performing this test, additional evaluation should occur.The physician will identify medical conditions affecting fall risk (for example, a recent stroke or medications that cause dizziness or hypotension) and the risk for significant complications of falls (for example, increased fracture risk in someone with osteoporosis or increased risk of bleeding in someone taking an anticoagulant).Falls should be categorized as those that occur while trying to rise from a sitting or lying to an upright position, those that occur while upright and attempting to ambulate, and other circumstances such as sliding out of a chair or rolling from a low bed to the floor.If the individual continues to fall, the staff and physician will re-evaluate the situation and reconsider possible reasons for the resident's falling (instead of, or in addition to those that have already been identified) and also reconsider the current interventions. As needed, and after an appropriately thorough review, the physician will document any uncorrectable risk factors andunderlying causes.II. Resident #34A. Resident statusResident #34, age [AGE], was admitted on [DATE]. According to the April 2026 computerized physician orders (CPO), diagnoses included vascular dementia, anxiety and PTSD.The 3/8/26 minimum data set (MDS) assessment documented the resident was unable to participate in the brief interview for mental status (BIMS) assessment. A staff assessment for mental status revealed she had short and long term memory loss and severely impaired decision-making abilities. The MDS assessment indicated the resident had behaviors of delusions, difficulty focusing her attention and disorganized thinking. The resident required moderate staff assistance with eating and personal hygiene. The resident only required staff supervision with toileting, showering, dressing, standing, transfers and walking. The assessment indicated the resident did not use a wheelchair. The assessment revealed the resident had not had any falls in the last six months. -However, the resident had an unwitnessed fall on 2/25/26 (see record review below). B. ObservationsDuring a continuous observation of Resident #34 in the common area on 4/20/26, beginning at 1:40 p.m. and ending at 2:57 p.m., the following was observed:At 1:40 p.m. Resident #34 was sitting in her wheelchair up against the wall in the common area across from the nurses' station. The medical records clerk was sitting at the nurses' station and two nurses were standing next to the nurses' station next to the medication cart. Resident #34 was watching the staff and then she bent down and moved her foot pedals on her wheelchair from the down position to the up position so the pedals were out of the way of her legs.At 1:42 p.m. Resident #34 put both of her hands on her arm rests and attempted to push herself up, but then sat back down. There was a staff member in the hallway three feet away from the resident and a nurse and the medical records clerk were at the nurses' station. However, no one interacted with the resident or tried to determine what she might (continued on next page)

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	065399	A. Building B. Wing	04/22/2026

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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	04/22/2026

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

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F 0689 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	wheelchair up against the wall in the common area across from the nurses' station. She put both of her hands on her arm rests and pushed herself up to a standing position. The resident stood up for five seconds and then sat back down. There were two nurses and a CNA all sitting at the nurses' station with their backs turned to Resident #34. None of the staff members observed Resident #34 standing up from her wheelchair. On 4/21/26 from 1:46 p.m. to 1:49 p.m. Resident #34 was sitting in her wheelchair up against the wall in the common area across from the nurses' station. The resident put her hands on her arm rests and attempted to push herself up to a standing position four times. A therapy staff member walked by but did not acknowledge Resident #34's multiple attempts to stand up. C. Record reviewThe fall care plan, revised 12/11/25, revealed Resident #34 was at risk for falls related to muscle weakness, back pain, dementia, insomnia, tremors, new-onset seizure (4/16/25) and medication side effects. Interventions included assisting the resident in keeping her room clutter free (initiated 2/26/26), encouraging the resident to call for assistance with ambulation/transfers when she was feeling ill or dizzy (revised 2/26/26) and not raising the footrest on her recliner (revised 4/20/26, during the survey). -The care plan failed to identify that new interventions were implemented or that the care plan was reviewed to determine if new interventions were needed following the resident's falls on 3/14/26, 3/27/26, 3/28/26, 3/31/26, 4/5/26 or 4/7/26 (see falls below). Review of Resident #34's April 2026 CPO revealed the following physician's orders:Abilify (an antipsychotic medication) 5 milligrams (mg). Give one tablet by mouth at bedtime for depression, ordered on 12/22/25.Mirtazapine (an antidepressant medication) 15 mg. Give one tablet by mouth at bedtime for insomnia, ordered on 12/22/25.Sertraline (an antidepressant medication) 100 mg. Give one tablet by mouth in the morning for depression, ordered on 12/22/25.Clonazepam (a benzodiazepine medication used to treat panic disorders) 0.5 mg. Give one tablet by mouth for anxiety, ordered on 3/17/26.Clonazepam 1 mg. Give one tablet by mouth at bedtime for insomnia, ordered on 3/17/26.Skilled physical therapy up to 36 times within 12 weeks to include therapeutic exercise, neuromuscular retraining, gait training, and wheelchair mobility/management, ordered on 4/3/26.Review of Resident #34's EMR, from 1/1/26 to 4/21/26, revealed the following:A pharmacist medication regimen review, dated 3/18/26, revealed the pharmacist had identified Resident #34 was on several medications that could increase her risk of falls, including clonazepam, sertraline, mirtazapine and Abilify. The pharmacist documented the following: Benzodiazepines are not recommended to be used in the elderly due to an increased risk of adverse effects, including death. Consider a slow taper off clonazepam, while increasing the dose of mirtazapine for insomnia. If the resident is experiencing anxiety, consider increasing the dose of sertraline for both anxiety and depression. Consider assessing the resident's vision to ensure it is not contributing to the resident's falls.The medical director (MD) responded that the resident's falls were unrelated to the above medications and no medication changes were warranted at this time. -Record review failed to reveal the facility made an optometrist appointment as recommended by the pharmacist in order to determine if possible changes in Resident #34's vision could be a potential contributor to the resident's falls. The physical therapy treatment plan, dated 4/3/26, revealed Resident #34 required therapy related to bilateral lower extremity weakness, impaired transfers, inability to walk, decreased activity tolerance and high fall risk. Physical therapy treatment notes, dated 4/3/26 to 4/22/26, revealed the resident would participate with bilateral upper extremity pull ups on hand rails but with limited tolerance for standing. The resident was inconsistent in agreeing to sessions, showing fear and anxiety related to weakness. -After 4/17/26, the resident stopped agreeing to physical therapy, however, no restorative therapy was recommended to maintain any functional gains the resident had achieved from therapy. 1. Fall on 2/25/26 - unwitnessed A fall progress note, dated 2/25/26, revealed Resident #34 was found sitting on the floor right inside her door with her knees bent in front of her. The resident was unable to tell the staff how she ended up on the floor.A post fall huddle, undated, revealed the resident did not sustain any injuries from the fall on 2/25/26. The root cause of the fall was determined to be due to an unsteady gait. No new interventions were documented as being put (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	04/22/2026

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
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F 0689 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	into place.A rehabilitation post-fall screen, dated 2/25/26, revealed that therapy recommended removing obstacles from the environment to prevent risk of falls and to set up the resident with television or music to redirect her attention. No skilled services (therapy) provided.2. Fall on 3/14/26-unwitnessedA fall occurrence note, dated 3/14/26, revealed Resident #34 was found in her room on the floor laying on her back with her legs bent up next to her bed. The resident was unable to tell the staff how she ended up on the floor.A post-fall huddle, undated, revealed the resident did not sustain any injuries from the fall on 3/14/26. The root cause of the fall was determined to be due to a new change in medication. The new intervention put into place was to conduct a medication review.A rehabilitation post-fall screen, dated 3/14/26, revealed that therapy recommended reviewing the resident's medications. No skilled services were provided.A rehabilitation post-fall screen, dated 3/23/26, revealed that therapy recommended reviewing the resident's medications. No skilled services were provided.-However, a rehabilitation post-fall screen had been previously conducted on 3/14/26 and the same recommendations had been given and no therapy services were provided.An alert note, dated 3/18/26, revealed Resident #34's clonazepam changed from 1 mg twice a day to 0.5 mg in the morning and 1mg in the evening.A follow up occurrence note, dated 3/20/26, revealed the resident was no longer ambulating independently and was unsteady on her feet. She had been in a wheelchair since 3/19/26. -Despite the resident having a change in her ability to participate in activities of daily living, there was no documentation to indicate the resident was assessed for a change of condition or that therapy was notified that she was no longer ambulating. 3. Fall on 3/27/26 - unwitnessedAn incident note, dated 3/27/26, revealed Resident #34 was found on the floor sitting on her bottom next to a chair near the nurses' station. The resident was unable to tell the staff how she ended up on the floor.A post-fall huddle, undated, revealed the resident did not sustain any injuries from the fall on 3/27/26. The root cause of the fall was determined to be due to the resident getting up from her wheelchair and not being strong enough to get up all the way. No new interventions were put into place.4. Fall on 3/28/26 - witnessedA post-fall huddle, undated, revealed the resident did not sustain any injuries from the fall on 3/28/26. The root cause of the fall was determined to be due to the resident attempting to sit on a chair in the common area. The new interventions put into place were to have physical therapy evaluate her, offer sensory activities, and ask her family to bring in snacks the resident preferred. -There were no progress notes documented in the resident's EMR regarding the fall. 5. Fall on 3/31/26 - witnessedA fall occurrence note, dated 3/31/26, revealed Resident #34 was observed sitting in a chair across from the nurses' station. The resident tried to stand, slid down onto the floor and landed on her buttocks. The resident was wearing non-skid socks, however they were noted to be slippery.A post-fall huddle, undated, revealed the resident did not sustain any injuries from the fall on 3/31/26. The root cause of the fall was determined to be due to the resident being unaware of her limitations. No new interventions were documented as being put into place.A rehabilitation post-fall screen, dated 4/2/26, revealed that the resident was on speech and physical therapy services.-However, therapy services were not implemented until after the resident had sustained four other falls (see above). 6. Fall on 4/5/26 - unwitnessedA fall occurrence note, dated 4/5/26, revealed the resident was found sitting on the floor in her room, feet facing the door, knees bent, scooting towards the door. The call light cord was under her legs and she was holding the call light in her right hand. She was last seen in her recliner with her call light. The resident was unable to tell the staff how she ended up on the floor.A post-fall huddle, undated, revealed Resident #34 did not sustain any injuries from the fall on 4/5/26. The root cause of the fall was determined to be due to the resident having weakness and she had difficulty sitting in her recliner. The new intervention put into place was to have the leg rest on her recliner be in the down position.7. Fall on 4/7/26 - unwitnessedA fall occurrence note, dated 4/7/26, revealed the resident was found sitting upright on the floor in her doorway. The staff determined the fall was due to the resident being unsteady on her feet and forgetting to use her wheelchair. The resident was unable to tell the staff how she ended up on the floor.A rehabilitation post-fall screen, dated 4/9/26, revealed (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	04/22/2026

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

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F 0689 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	that the resident was on speech and physical therapy services. -There were no post-fall huddles or new interventions documented in the resident's EMR.III. Staff interviewsCNA #3 was interviewed on 4/20/26 at 1:31 p.m. CNA #3 said she was not sure how to find fall interventions for the residents in their EMRs. CNA #3 said she did not know what Resident #34's fall interventions were. She said therapy was no longer working with the resident because she kept falling down. Licensed practical nurse (LPN) #3 was interviewed on 4/21/26 at 3:06 p.m. LPN #3 said fall interventions should be in the residents' care plans, but she was not sure how the CNAs found the fall interventions. LPN #3 said she had not looked at Resident #34's fall interventions in a long time but believed the intervention was to encourage activities for the resident. LPN #3 said therapy was working with Resident #34 on strengthening and pivoting. She said when the resident was in the common area, the staff were to keep an eye on her and redirect her if she tried to stand up.-However, multiple observations revealed staff were not monitoring the resident closely when she was in the common area (see observations above). The DON was interviewed on 4/22/26 at 9:04 a.m. The DON said Resident #34 had anxiety and sitting in the wheelchair seemed to give her a feeling of security. The DON said that the resident had a lack of strength, so therapy was implemented, sensory activities were offered, and the resident's recliner was removed from her room. She said it was the resident's preference to be seated in the common area. She said when the resident's falls were reviewed, the root cause was determined to be due to her trying to get out of her recliner in her room. The DON was informed of the observations that occurred of Resident #34 in the common area during the survey and she said she would not have expected the staff to do anything different. She said the staff had tried to offer independent sensory activities to the resident and offer group activities, but the resident did not seem interested. The DON said there were volunteers that came to see the resident and she responded very well to them. She said the volunteers did individual activities with her and visited with her. The DON said she had not analyzed what the volunteers were doing with the resident that was working in order to incorporate those interventions into the resident's plan of care to prevent falls. She said other than seating the resident in the common area and offering therapy, she was not aware of any other individualized fall interventions that could be implemented for Resident #34.

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	04/22/2026

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F 0698 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide safe, appropriate dialysis care/services for a resident who requires such services. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on record review and interviews, the facility failed to ensure residents who required dialysis services received services consistent with professional standards of practice for one (#2) of one resident reviewed for dialysis out of 31 sample residents. Specifically, the facility failed to ensure staff was assessing and documenting on Resident #2's dialysis fistula (the connection between an artery and a vein for hemodialysis) site on a routine basis.Findings include:I. Professional referenceAccording to Lok, [NAME], et al., Hemodialysis Vascular Access: Core Curriculum 2025, American Journal of Kidney Foundation, (2025), retrieved on 4/28/26 from https://www.ajkd.org/article/S0272-6386%2824%2900976-4/fulltext#:~:text=Intraoperative%20mapping%20by An arteriovenous fistula (AVF), created by an anastomosis (surgical connection) between a native artery and a vein, is the recommended vascular access for patients requiring hemodialysis due to its substantially lower rates of thrombosis (blood clots), infection, and health care-related expenditures (costs). The AVF should have a palpable thrill (a buzzing vibration felt by hand) and a continuous bruit (an audible whooshing sound heard with a stethoscope). The rationale for monitoring is that detection of a vascular access abnormality (such as stenosis - the narrowing of vessels) in AVF can lead to a pre-emptive (early) intervention to correct a stenosis, prevent a vascular access thrombosis from occurring and improve overall vascular access patency and function. The main principles of physical examination include inspection, palpation (touch), and auscultation (listen) of the vascular access to detect for signs of stenosis and pathologic abnormalities within the vascular access.II. Facility policy and procedureThe Hemodialysis Resident policy, undated, was provided by the nursing home administrator (NHA) on 4/22/26 at 6:42 p.m. It read in pertinent part, The vascular site will be monitored daily for thrills and auscultate (listen) for bruits. If not present, then notify the physician immediately. No invasive procedures will be done on the resident's arm in which the access site/fistula is placed. The resident's access site will be assessed every (q) shift and documented.III. Resident #2A. Resident statusResident #2, age greater than 65, was admitted on [DATE]. According to the April 2026 computerized physician orders (CPO), diagnoses included sepsis, type 2 diabetes mellitus, end stage renal disease, chronic stage 5 kidney disease and dependence on renal dialysis.The 3/9/26 minimum data set (MDS) assessment revealed the resident was cognitively intact with a brief interview for mental status (BIMS) score of 15 out of 15.The MDS assessment indicated the resident was dependent on renal dialysis and received renal dialysis upon admission and while in the facility. B. Record reviewReview of Resident #2's admission evaluation, dated 3/7/26, revealed the resident had a genitourinary diagnosis, such as dialysis, received hemodialysis and had edema (swelling) to the left arm.-However, the admission evaluation failed to identify the resident's right chest dialysis port or his left arm dialysis fistula.Resident #2's re-admission evaluation, dated 4/16/26, revealed the resident had a genitourinary diagnosis, received hemodialysis and had edema to the left arm due to the dialysis shunt.-However, the re-admission evaluation failed to identify the resident's right chest dialysis port.Review of Resident #2's April 2026 CPO revealed the following physician's orders:Monitor the central venous catheter (CVC) site every shift for signs of infection, ordered 3/25/26.Dialysis: Monitor site for bleeding and signs or symptoms of infection (right chest), ordered 3/9/26.-However, there was no physician's order to assess and monitor Resident #2's left arm fistula site. Review of Resident #2's electronic medical record (EMR), including progress notes and skilled nursing documentation, revealed the resident's left arm was edematous, and the resident required dialysis services.-However, there was no documentation in the EMR to indicate that Resident #2's left arm fistula was being assessed and monitored routinely.IV. Staff interviewsThe dialysis registered nurse (RN) was interviewed on 4/22/26 at 9:46 a.m. The dialysis RN worked at Resident #2's dialysis center. The dialysis RN said Resident #2 had both a right chest dialysis port and a left arm arteriovenous fistula in place.RN #2 was interviewed on 4/22/26 at 11:08 a.m. RN #2 said she (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	04/22/2026

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

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F 0698 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	would know if a resident had a dialysis port or fistula because it would be documented on the resident's admission documentation. She said before a resident left the facility for dialysis, the charge nurse should measure the resident's vital signs and document them on the dialysis communication handoff form. RN #2 said when a resident returned from dialysis, the nurse should take another set of vital signs to make sure the resident was stable, ask the resident how they were feeling and assess the resident's fistula site for bleeding. She said if there were any abnormalities with the resident's fistula site, the physician would be notified. RN #2 said Resident #2 had both a dialysis port and an arteriovenous fistula. She said she was not sure if the resident's fistula should be assessed every day or every shift. RN #2 searched the resident's EMR for a moment, then said the fistula should be assessed every shift.-However, there was not a physician's order for the dialysis fistula to be assessed every shift in the resident's April 2026 CPO (see physician's orders above).The director of nursing (DON) was interviewed on 4/22/26 at 1:15 p.m. The DON said the facility knew an admitting resident would be on dialysis because it would be documented in the primary referral and the resident's medical diagnosis. She said Resident #2 had both a dialysis port and an arteriovenous fistula. The DON said the nursing staff did not touch the resident's dialysis port, they just monitored the site for signs and symptoms of infection. She said the resident's fistula should be monitored daily for bruit and thrill, and it should have been documented in the skilled nursing assessments in the resident's EMR.The DON looked in Resident #2's EMR for separate physicians' orders to monitor both the resident's dialysis port and the fistula. She said there was not a physician's order to assess Resident #2's fistula, but there would be an order going forward. The DON said there should have been a physician's order to monitor Resident #2's arteriovenous fistula. She said it was important to monitor the dialysis sites in order to monitor the resident's disease process.V. Facility follow-upDuring the interview with the DON on 4/22/26 at 1:15 p.m. (see above), the DON updated Resident #2's April 2026 CPO with the following physician's order:Monitor the left upper extremity dialysis site for bruit and thrill and notify the physician if absent. Every shift, document (+) for no issues and (-) for issues noted to the site. If issues are noted, then notify the physician, ordered 4/22/26.-However, there was no documentation to indicate the nursing staff were assessing and documenting on Resident #2's left arm dialysis fistula until the concern was brought to the facility's attention during the survey.

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	04/22/2026

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

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F 0756 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure a licensed pharmacist perform a monthly drug regimen review, including the medical chart, following irregularity reporting guidelines in developed policies and procedures. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on record review and interviews, the facility failed to provide a rationale to act upon the pharmacist's recommendations in a timely manner for one (#15) of nine residents out of 31 sample residents. Specifically, the facility failed to provide a rationale for not acting upon the pharmacist's recommendations for Resident #15.Findings include: I. Facility policy and procedure The Medication Regimen Reviews policy and procedure, revised 2/25, was provided by the nursing home administrator (NHA) on 4/22/26 at 10:10 a.m. It revealed in pertinent part, Upon receiving the medication recommendation report (MRR) from the pharmacist, the physician reviews and responds to the report. The physician documents in the resident's medical record that the pharmacist's recommendation has been reviewed and what actions were taken to address them. II. Resident #15A. Resident status Resident #15, age less than 65, was admitted on [DATE]. According to the April 2026 computerized physician orders (CPO), diagnoses included traumatic brain injury, bed confinement, anxiety disorder, quadriplegia, neuromuscular dysfunction, dementia and insomnia.The 3/24/26 minimum data set (MDS) assessment revealed the resident was cognitively intact with a brief interview for mental status (BIMS) score of 15 out of 15. She had impairments on both upper and lower extremities and used a wheelchair. She required partial assistance with eating and substantial assistance with oral hygiene. She was dependent on toileting, showering, personal hygiene and dressing. The assessment revealed she had an anxiety disorder. She took an antipsychotic medication, an antianxiety medication, an antidepressant medication, a hypnotic medication, and an opioid medication. The assessment revealed she took antipsychotic medications on a routine basis and a gradual dose reduction (GDR) was attempted on 7/21/25. The physician documented a GDR as clinically contraindicated on 7/21/25. The assessment revealed the section asking if the complete drug regimen review identified potential clinically significant medications was not marked and the section asking if the facility contacted the physician by midnight of the next calendar day and completed prescribed recommended actions in response to the identified potential clinically significant medication issues was not marked. B. Resident interview Resident #15 was interviewed on 4/20/26 at 9:38 a.m. Resident #15 said her pain was controlled with medication and the nurse just gave her pain medication. Resident #15 said her pain level was zero. Resident #15 said she had gained weight since she was admitted to the facility. She said she tried to choose veggies and fruit. C. Record reviewReview of Resident #15's April 2026 CPO revealed the following physician's order: Mirtazapine (an antidepressant medication) 15 milligrams (mg). Take one tablet by mouth at bedtime for insomnia, ordered 3/9/26. Risperdal (an antipsychotic medication) 1 mg. Take one tablet by mouth two times a day for uncontrolled yelling, ordered 3/9/26 and discontinued 4/14/26.Risperdal 1 mg. Take 0.5 tablet by mouth two times a day for tapering the dose until 4/21/26, ordered 4/14/26. Risperdal 1 mg. Take 0.5 tablet by mouth in the morning for tapering the dose until 4/29/26, ordered 4/22/26. Gabapentin (an anticonvulsant medication) 300 mg. Take one capsule by mouth three times a day for pain, ordered 7/9/24. Oxycodone 5 mg. Take one tablet by mouth three times a day for pain and discomfort, ordered 7/9/24. Tylenol 500 mg. Take two tablets by mouth three times a day for pain, ordered 7/7/24. Pain monitoring. Assess for pain every shift, ordered 1/2/25.Review of Resident #15's March 2025 medication administration record (MAR) and April 2025 MAR (from 3/1/26 to 4/20/26) revealed the resident's pain level had been assessed two times each day during the timeframe. The resident's pain level was documented as a 0 out 10 for each pain assessment. Review of the medication regimen review (MRR) forms provided by the facility revealed there were two sections on the form. The first section was completed by the pharmacist and provided a recommendation. The second section was the physician's response section. The physician's response section had three options for the physician to check; agree, disagree or other. If the physician marked (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	04/22/2026

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

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F 0756 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	disagree, the form instructed the physician to document a clinical rationale at the bottom of the form. Review of Resident #15's MRR from 3/1/25 to 4/1/26, revealed the following: On 12/30/25, the pharmacist recommended decreasing the resident's dose or frequency of oxycodone 5 mg. The resident took oxycodone 5 mg three times a day and all recent pain levels were zero. The physician's response section was marked disagree. -However, the physician did not document a clinical rationale to explain the reason for not decreasing the resident's oxycodone, as was recommended by the pharmacist.-Additionally, review of Resident #15's electronic medical record (EMR) did not reveal a rationale for why the pharmacist's recommendations regarding the resident's oxycodone were not addressed.On 2/10/26, the pharmacist recommended obtaining routine A1c levels (a blood lab test that averages blood glucose levels to diagnose or monitor diabetes) or finger stick blood sugar checks (a finger stick blood sugar test to provide immediate, real-time measurement of blood glucose levels) monthly because Resident #15 was receiving Risperdal twice daily. The physician response section was marked disagree.-However, the physician did not document a clinical rationale to explain the reason for not obtaining A1c levels or routine finger stick blood sugar checks, as was recommended by the pharmacist.-Additionally, review of Resident #15's EMR did not reveal a rationale for why the pharmacist's recommendations regarding the resident's A1c or routine finger stick blood sugar checks were not addressed. On 3/18/26, the pharmacist recommended decreasing the resident's dose of Lexapro to 15 mg daily due to Resident #15 having started mirtazapine for insomnia. The resident was taking Lexapro for anxiety, however, Lexapro was an activating antidepressant and could cause insomnia. The physician's response was marked disagree.-However, the physician did not document a clinical rationale to explain the reason for not decreasing the resident's Lexapro, as was recommended by the pharmacist.-Additionally, review of Resident #15's EMR did not reveal a rationale for why the pharmacist's recommendations regarding decreasing the resident's Lexapro were not addressed. III. Staff interviews The director of nursing (DON) was interviewed on 4/21/26 at 4:30 p.m. The DON said she was new to the position of being a DON. She said she was responsible for reviewing the pharmacist's recommendations. She said she was aware the physician disagreed with the pharmacist's recommendations. The DON said the physician did not provide a rationale for why he disagreed with the recommendations. She said the physician was responsible for reviewing the pharmacist's recommendations. She said she printed the recommendations and the physician reviewed the recommendations when he was in the facility, which was once a week on Mondays. She said once the physician reviewed the pharmacist's recommendation, the pharmacy provided a DON report that summarized the recommendations. The DON said in addition to the physician's report that required the physician's review due to needing a physician's order, she received a DON report from the pharmacy that summarized the pharmacist's recommendations from the physician's report. The DON said she hand wrote if the physician wanted to make any changes on the DON report. -However, review of the DON report did not reveal documentation to indicate a rationale for why the pharmacist's recommendations were not addressed for Resident #15. The DON said she was familiar with Resident #15. She said she was aware the pharmacist recommended obtaining A1c levels or monthly fasting blood sugar checks due to Resident #15 being on risperidone (which can cause weight gain). She said she did not know the rationale the physician provided for not ordering laboratory (lab) blood work to be drawn or a monthly fasting blood sugar check. The DON said she was aware of the pharmacist's recommendation to decrease Resident #15's dose or frequency of oxycodone 5 mg due to the resident reporting pain levels of zero. The DON said she did not know the physician's rationale for not decreasing the dose or frequency of the resident's oxycodone. The DON said she was aware the pharmacist recommended decreasing Resident #15's Lexapro from 20 mg to 15 mg due to the resident starting mirtazapine for insomnia. The DON said she did not know the physician's rationale for not decreasing the resident's Lexapro dose. The DON said she was aware Resident #15 had gained weight. She said Resident #15 had asked for new clothes because she did not fit in the clothes she wore. The DON said she was aware mirtazapine not only helped with insomnia but with appetite loss. (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	04/22/2026

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

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F 0756 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	She said she talked to the physician about Resident #15's weight gain and he did not provide a rationale for not changing any of Resident #15's medications. Pharmacist #1 was interviewed on 4/22/26 at 2:45 p.m. Pharmacist #1 said she was the supervising pharmacist for the facility's pharmacist (pharmacist #2) who was unavailable. She said a pharmacist reviewed each resident's medications once a month and as needed. She said once a resident's medications were reviewed, there were three reports the pharmacist provided to the facility. She said the first report was a list of residents who were reviewed and no recommendations were made. Pharmacist #1 said the second report was a list of residents who the pharmacist made recommendations that the physician needed to review. She said the third report was a list of residents who the pharmacist made recommendations for that the DON needed to review. Pharmacist #1 said the pharmacist's recommendations should be reviewed as soon as possible and at the latest, reviewed within 30 days. She said once the pharmacist made a recommendation, the physician needed to check if they agreed with the recommendation, disagreed or make other comments. She said if the physician disagreed, the physician should document the rationale in the space provided on the form. Pharmacist #1 said the pharmacists followed up to see what the physician's response was. Pharmacist #1 said she was not familiar with Resident #15. Pharmacist #1 said she was aware the facility's physician was not agreeing with the recommendations made by pharmacist #2 and was not providing a rationale as to why the recommendations were not agreed with. She said it was very common for the physician to disagree with the pharmacist's recommendation and there were many conversations about concerns without providing a rationale for disagreeing with the recommendations. Pharmacist #1 said she would have pharmacist #2 call when he was available to talk about Resident #15. Pharmacist #2 was interviewed on 4/27/26 at 4:59 p.m., upon his return to the pharmacy. Pharmacist #2 said he had been the facility's pharmacist consultant for eight years. He said he had not been responsible for the medication regimen reviews since May 2025. Pharmacist #2 said a pharmacist reviewed each resident's medication regimen once a month and as needed. He said the pharmacist shared three reports with the facility. He said the first report was a list of residents who were reviewed and no recommendations were made. Pharmacist #2 said the second report was a list of residents who the pharmacist made recommendations for that the physician needed to review. He said the third report was a list of residents who the pharmacist made recommendations for that the DON needed to review. Pharmacist #2 said the recommendations should be reviewed as soon as possible and at the latest, they needed to be reviewed within 30 days. He said once the pharmacist made a recommendation, the physician needed to check if they agreed with the recommendation, disagreed or make other comments. He said if the physician disagreed, the physician should document the rationale in the space provided on the form. Pharmacist #2 said the pharmacist followed up to see what the physician's response was. Pharmacist #2 said he was familiar with Resident #15 based on attending quarterly psychotropic pharmacy meetings with the facility. Pharmacist #2 said he said he had not completed MRRs for the facility since May 2025 and another pharmacist was now responsible for that. Pharmacist #2 said he was not aware of the pharmacist's recommendations for Resident #15 and was not aware Resident #15 had gained weight. He said a pharmacist would recommend an A1c or a finger stick blood sugar test because it helped to see if the medication caused anything to change metabolically.Pharmacist #2 said medication regimen review was important because it was vital for the resident. He said often there were residents who were unable to advocate for themselves and monthly medication review was one way for pharmacists to advocate for the resident. He said monthly medication review was a way to optimize pharmacy therapy and the pharmacists strived to provide the highest quality of life to the facility's residents. Pharmacist #2 said when he completed the facility's MRRs previously, he knew the physician did not agree with the pharmacist's recommendations. He said it was important for the physician to provide a rationale for why they disagreed with the recommendations because it helped understand where the physician was coming from.

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	04/22/2026

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

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F 0881 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Implement a program that monitors antibiotic use. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on record review and interviews, the facility failed to establish an effective antibiotic stewardship program that included antibiotic use protocols and a system to monitor antibiotic use for one (#34) of four residents reviewed for antibiotic stewardship out of 31 sample residents. Specifically, the facility failed to ensure Resident #34's antibiotic therapy for a potential urinary tract infection (UTI) was discontinued in a timely manner after the facility received a negative urine culture and sensitivity (C&S - a test that identifies the organism in the urine and determines the most effective antibiotic therapy) report.Findings include:I. Professional referenceAccording to The Centers for Disease Control and Prevention's (CDC) Core Elements of Antibiotic Stewardship for Nursing Homes, (2024), retrieved on 4/27/26 from https://www.cdc.gov/antibiotic-use/hcp/core-elements/nursing-homes-antibiotic-stewardship.html, To track how and why antibiotics are prescribed, providers perform reviews on resident medical records for new antibiotics started to determine whether the clinical assessment, prescription documentation and antibiotic selection were in accordance with facility antibiotic use policies and practices. When conducted over time, monitoring process measures can assess whether antibiotic prescribing policies are being followed by staff and clinicians.II. Facility policy and procedureThe Antibiotic Stewardship policy, dated December 2016, was provided by the nursing home administrator (NHA) on 4/22/26 at 6:43 p.m. It read in pertinent part, The purpose of our Antibiotic Stewardship program is to monitor the use of antibiotics in our residents. When a culture and sensitivity (C&S) is ordered, lab (laboratory) results and the current clinical situation will be communicated to the prescriber as soon as available to determine if antibiotic therapy should be started, continued, modified or discontinued.III. Resident #34A. Resident statusResident #34, age [AGE], was admitted on [DATE]. According to the April 2026 computerized physician orders (CPO), diagnoses included vascular dementia (a decline in thinking skills caused by blockages/reduced blood flow to the brain), seizures, osteoarthritis and adult failure to thrive. The 3/8/26 minimum data set (MDS) assessment revealed a brief interview for mental status (BIMS) score of 99, which indicated the resident was unable to complete the assessment. The staff assessment for mental status revealed the resident had severely impaired cognition and rarely made decisions.B. Record reviewReview of Resident #34's electronic medical record (EMR) revealed the following progress notes:On 2/2/26 at 1:33 p.m. Resident #34 expressed pain/burning with urination. The charge nurse, registered nurse (RN) #2, was notified, said she would notify the physician and perform a urine dip.On 2/3/26 at 4:50 p.m. Resident #34 had a urine dip completed which identified protein and leukocytes (white blood cells) in the resident's urine. The physician was notified and a physician's order for Macrobid (an antibiotic medication) was obtained. A urine sample sent to the lab for a C&S report. The resident's representative was notified via phone.On 2/6/26 at 5:03 p.m. Resident #34's urine C&S report came back on the urine sample. Final results indicated there was less than 10,000 colony-forming units per milliliter (CFU/mL) of urogenital flora at day one and 20,000-30,000 CFU/mL mixed flora (usually indicates low-level growth of multiple bacterial types, often suggesting contamination from the skin or genital area rather than a true infection) at day two. The physician was notified.On 2/7/26 at 5:24 p.m. Resident #34 continued to receive macrobid. The note indicated the C&S report came back negative for UTI. On 2/10/26 at 12:50 p.m. The physician was contacted for a stop date for Resident #34's Macrobid. The physician said the medication should have been taken for five days, so the medication was discontinued.-However, the facility failed to ensure Resident #34 did not receive antibiotics unnecessarily and the resident was administered Macrobid for seven days before it was discontinued (see below).Review of Resident #34's February 2026 CPO revealed the following physician's order:Macrobid oral capsule 100 milligrams (mg), give one capsule by mouth two times a day for UTI, ordered 2/3/26 at 8:00 a.m. and discontinued on 2/10/26 at 12:49 p.m.-Review of (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	04/22/2026

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

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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 0881 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Resident #34's February 2026 medication administration record (MAR) revealed the resident was administered an additional eight doses of Macrobid after the facility received the negative urine C&S report on 2/7/26 and before it was discontinued by the physician on 2/10/26.IV. Staff interviewsThe infection preventionist (IP) was interviewed on 4/22/26 at 1:35 p.m. The IP said the biggest goal of the antibiotic stewardship program was to work with the medical director (MD) to try to get him more on board with antibiotic stewardship. She said the facility used McGeer's criteria (standardized, evidence-based criteria used to identify infections in long-term care (LTC) facilities) and wanted the physician to utilize the same criteria. The IP said in this resident population, a change in mental status did not always mean a UTI was present, but if the physician at the facility was notified about a change in a resident's mental status, he would start Macrobid. The IP said the facility should be investigating further by waiting for the urine C&S report to return prior to starting the resident on antibiotics.The IP searched the charge nurse's phone for communication between the nursing staff and the MD regarding the discontinuation of Resident #34's Macrobid order, however, she was unable to find additional information. She said she made a progress note when she discontinued the Macrobid and included a note that the Macrobid was intended for five days.The IP said Resident #34's Macrobid order should have been discontinued on 2/7/26 when the urine C&S report came back, but she did not see the result until she called the physician on 2/10/26. She said it was important that antibiotic therapy was used only when clinically relevant so the facility did not get colonized residents (bacteria present on or in a host, such as skin, gut, or respiratory tract that grow without causing an immune response) or multidrug resistant organisms (MDROs - bacteria and other microorganisms that have developed resistance to multiple or all commonly used antibiotics and antimicrobial agents).