STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	065331	A. Building B. Wing	03/11/2025

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

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0600 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Protect each resident from all types of abuse such as physical, mental, sexual abuse, physical punishment, and neglect by anybody. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 51163 Based on observations, record review and interviews, the facility failed to ensure three (#1, #8 and #6) of three residents were kept free from abuse out of nine sample residents. Specifically, the facility failed to: -Protect Resident #1 and Resident #8 from being sexually abused by Resident #2; and, -Protect Resident #6 from physical abuse by Resident #5. Findings include: I. Facility policy and procedure The Abuse Prevention, Investigation and Reporting policy and procedure, revised November 2022, was provided by the nursing home administrator (NHA) on 3/11/25 at 5:14 p.m. It read in pertinent part, To ensure to the extent possible, that every resident is free from abuse, neglect, misappropriation of resident property, and exploitation. The resident has the right to be free from abuse (including verbal, mental, sexual and physical), neglect, misappropriation of resident property and exploitation. This includes freedom from corporal punishment, involuntary seclusion and any physical or chemical restraint not required to treat a resident's medical condition. Management will take specific steps to reduce the potential for abuse to occur at the facility including, but not limited to education, monitoring and investigating thoroughly if abuse, misappropriation, neglect, or exploitation is suspected. Sexual abuse includes, but is not limited to sexual harassment, sexual coercion, or sexual assault. Physical abuse includes, but is not limited to, hitting, slapping, pinching and kicking. It also includes controlling behavior through corporal punishment. (continued on next page)

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

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

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F 0600 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	The admissions coordinator will do a pre-assessment on all potential admissions to see if there is a history of abusive behavior. If any potential admission has a history of abusive behavior, the admissions coordinator will notify the administrator and/or the director of nursing services. The administrator will make the final determination on whether or not to admit, upon consultation with the director of nursing services and/or other appropriate personnel. The facility will conduct assessment, care planning and monitoring of residents with needs and behaviors which might lead to conflict or neglect including self-injurious behaviors. Resident to resident incident: The abusive resident will be separated from other residents for a limited period as a therapeutic intervention to reduce agitation and potential for harm and ensure the safety of other residents. Other interventions will also be considered to include, but not limited to, family assistance, change of roommates, physician review of appropriate medication(s), consult with psychology, and other interventions as outlined in the resident's person-centered plan of care. II. Sexual abuse of Resident #1 and Resident #8 by Resident #2 A. Facility investigation for sexual abuse of Resident #1 by Resident #2 on 12/18/24 The facility investigation, dated 12/18/24, documented at approximately 1:15 p.m. revealed Resident #1 was walking throughout the facility. Resident #2 invited Resident #1 into his room and closed the door. It was not normal behavior for Resident #2 to want his door closed so the staff followed them into the room. Upon opening the door, the staff member saw Resident #2 had his hand on Resident #1's crotch, over her clothing. The staff member was able to separate the two residents. Resident #1 was tearful after the event but she was not able to explain her emotions to staff due to her severely impaired cognition. The investigation documented Resident #1 was assisted back to her hallway. Resident #2 and Resident #1 were both placed on line-of-sight supervision and both residents were to be redirected from interacting with each other. Resident #1 was encouraged to participate in activities programming to prevent unsafe wandering. The interim social services director (ISSD) interviewed Resident #2 on 12/19/24. Resident #2 was defensive about the incident. He initially said he ignored Resident #1 and she was not in his room. Resident #2 was educated that Resident #1 was not able to consent to engage in sexual intimacy. Resident #2 responded by telling the ISSD that Resident #1 understood more than she let on and that he felt sorry for her when she was crying. The ISSD educated Resident #2 that his behavior was unacceptable and was not to continue. The ISSD interviewed certified nurse aide (CNA) #2 on 12/19/24. CNA #2 said she had witnessed Resident #2 inviting other female residents into his room on several prior occasions. CNA #2 said she was uncomfortable when she observed him inviting Resident #1 into his room and shutting the door. The facility substantiated the allegation of sexual abuse. B. Facility investigation for sexual abuse of Resident #8 and Resident #1 by Resident #2 on 2/22/25 (continued on next page)

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F 0600 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	The facility investigation, dated 2/22/25 documented at 1:09 p.m., revealed Resident #2 was self-propelling in his wheelchair in the common area hallway when he approached Resident #8, who was sitting in the hall in her wheelchair. The investigation documented it appeared that the residents were having a conversation. As staff approached, it was noted that Resident #2 had his hand on Resident #8's thigh and was moving his hand towards her inner thigh. Resident #8 said, No, stop! and motioned for Resident #2 to move his hand. The CNA told Resident #2 to stop and Resident #2 left the area. -Interviews later in the day revealed that the CNA who intervened in the 1:30 p.m. incident with Resident #8 did not report the incident until being questioned after the second similar incident with Resident #1 occurred at 5:30 p.m. (see below). -There was no documentation in the investigation report indicating that either resident was interviewed about the details of the incident. The second facility investigation, dated 2/22/25, documented at 5:30 p.m. Resident #1 was walking near the nurse's station and Resident #2 was self-propelling in his wheelchair behind Resident #1. As Resident #1 got closer to Resident #2 he reached out and placed his hand on the back of Resident #1's thigh and began to move his hand higher up her thigh. Resident #1 turned and tried to swat his hand away. The investigation documented her action of trying to swat his hand away did not stop him from his actions. A nearby CNA had to intervene and remove Resident #2's hand from Resident #1's leg before he was able to move his hand to her private areas. The residents were separated. The CNA took Resident #1 to a safe area and a second CNA took Resident #2 to another location. The investigation revealed Resident #1 was very tearful after the incident. The staff were unsure if the tearfulness was due to the incident or due to her baseline of having tearfulness on and off. -There was no documentation that the facility assessed Resident #1's level of tearfulness throughout the day to determine if she was more tearful than usual following the incident. -Despite Resident #2 being placed on 15-minute checks when out of his room, he was able to sexually abuse two female residents in the common area of the facility on the same day (see Resident #2's care plan below). C. Resident #1 - victim 1. Resident status Resident #1, age 81, was admitted on [DATE]. According to the March 2025 computerized physician orders (CPO), diagnoses included Alzheimer's disease, dementia with severe mood disturbance and depression. According to the 2/12/25 minimum data set (MDS) assessment, Resident #1 was unable to complete the brief interview for mental status (BIMS). The staff assessment revealed she had short-term and long-term memory deficits. The staff assessment further revealed she was severely impaired in her daily decision-making and that she had difficulty focusing her attention and was disorganized with her thinking. (continued on next page)

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F 0600 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	The MDS assessment documented that Resident #1 did not wander and could ambulate independently but needed staff assistance with most of her activities of daily living (ADL). -However, interviews and further record review revealed Resident #1 did wander (see interviews and record review below). 2. Resident #1's representative interview Resident #1's representative was interviewed on 3/10/25 at 3:20 p.m. The representative said the facility did tell him the inappropriate touching had happened twice. He said the facility was trying to keep an eye on both of the residents. 3. Observations During a continuous observation on 3/10/25, beginning at 3:45 p.m. and ending 4:36 p.m., the following was observed: At approximately 3:45 p.m. Resident #1 walked past Resident #2 in his hallway, but there was no interaction between the two residents. Resident #1 stopped to talk with other residents as she wandered the hall and then walked back up the hall to another resident unit without direct staff supervision or interaction. At 4:07 p.m. Resident #1 was sitting in a recliner in the common area eating a sucker. At 4:11 p.m. Resident #1 was sitting in a recliner in the common area with her eyes closed. At 4:21 p.m. Resident #1 was sitting in a recliner in the common area with her eyes closed. At 4:28 p.m. Resident #1 was walking around in the common area, she would stop at the nurse's station. The staff did not acknowledge her. At 4:32 p.m. Resident #1 was touching an unidentified male resident on his arm. She then placed her arm under and around his arm to walk arm and arm with him while he was walking. The social services assistant (SSA) was working with the male resident. -The SSA did not offer any prompting or cueing to Resident #1 to ensure she did not place herself in a vulnerable position while interacting with the male resident. At 4:36 p.m. Resident #1 was wandering around the nurse's station, the nurses did not acknowledge her. On 3/11/25 at 2:35 p.m. Resident #1 was wandering around the hallways and front lobby. There were no staff present. She wandered into the administrative offices and one of the administrative staff escorted her back to the nurse's station. -The staff failed to follow the interventions on Resident #1's care plan to monitor her wandering and offer meaningful activities or socialization to ensure a safe comfortable environment. (continued on next page)

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F 0600 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	E. Resident #2 - assailant 1A. Resident status Resident #2, age greater than 65, was admitted on [DATE]. According to the March 2025 CPO, diagnoses included cerebrovascular disease (stroke), Alzheimer's disease and diabetes. The 1/3/25 MDS assessment revealed Resident #2 had moderate cognitive impairments with a BIMS score of 12 out of 15. The assessment revealed Resident #2 needed supervision or minimal assistance with most of his ADLs. The assessment revealed he used his wheelchair but was able to self-propel on his own. The assessment indicated that Resident #2 did not display inappropriate behaviors. -However, record review and interviews revealed that Resident #2 displayed sexually inappropriate behaviors on 12/18/25, prior to the assessment. 2. Record review The behavior care plan, revised 12/26/24 and 1/17/25, documented Resident #2 was at risk for potential sexual advances toward others. Interventions included discussing the resident's behavior with the resident, reinforcing why the behavior was inappropriate, diverting other residents from wandering or entering Resident #2's room and intervening, as appropriate, to protect the rights and safety of others. -The care plan was not initiated until a week after the 12/18/24 incident with Resident #1. Review of Resident #2's EMR revealed that his behaviors were being monitored. -However, the behavior monitoring did not document that he was sexually inappropriate on 2/22/25. The behavior monitoring (reviewed from 2/10/25 to 3/10/25) further revealed that the monitoring was not being done consistently. Several shifts and entire days lacked documentation of any potential behaviors or absence of behavior. The 11/11/24 social services note documented that Resident #2 had kissed a female resident. After the incident was observed, social services staff met with Resident #2 to provide education that his behavior was inappropriate because the female resident (Resident #1) was considered a vulnerable person and unable to engage in intimate relationships. The 11/13/24 nursing note documented that Resident #2 placed his hand on Resident #1's leg while she was walking and that she almost fell due to his touching. The note documented that he was instructed to avoid Resident #1 and to stop touching her. -Neither of the above incidents resulted in a care plan focused on interventions to address Resident #2's inappropriate sexual behavior towards a resident who was assessed to be unable to consent to sexual intimacy. The resident's care plan was not revised until after the 12/18/24 incident (see above). (continued on next page)

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F 0600 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	The 12/18/24 nursing note documented that Resident #1 was found in Resident #2's room and Resident #2 was touching Resident #1 inappropriately. The note documented that Resident #2 received education on keeping his hands to himself and that he told staff he understood the education. -Review of Resident #2's EMR failed to reveal documentation related to the incident on 2/22/25. An email, dated 2/23/25, was provided by the NHA on 3/11/25. The email documented communication between the facility leadership team and Resident #2's physician's office. The email revealed that the facility initiated a request for assistance to find a more appropriate placement for Resident #2 in the interest of keeping the female residents in the facility safe. The 3/4/25 social services note documented that Resident #2's representative and Resident #2 were both informed that Resident #2 was being issued a 30-day discharge notice due to his continued inappropriate sexual behavior towards female residents in the facility. -Review of Resident #2's EMR revealed Resident #2 was educated that Resident #1 was unable to engage in any type of intimate relationship and he was instructed to not pursue any type of intimate relationship with Resident #1. E. Staff interviews Registered nurse (RN) #2 was interviewed on 3/10/25 at 3:45 p.m. RN #2 said Resident #1's physician stopped her olanzapine on 3/4/25, which made her more tearful due to the lack of medications. She said Resident #1 wandered unsafely into other resident's rooms and tried to exit the facility to the outside so the staff kept an eye on her because she wandered into another resident's rooms and had gotten taken advantage of in the past. CNA #1 was interviewed on 3/11/25 at 9:00 a.m. CNA #1 said the staff were expected to monitor all residents with wandering behaviors, especially if the resident wandered off the unit. She said Resident #1 liked to wander and did not spend a lot of time in her room. CNA #1 said staff watched Resident #1 because she liked to go into other residents' rooms and tried to use their bathrooms. She said they had to watch Resident #1 when she was near Resident #2's room but that he was on 15-minute checks and was supposed to be in staff's line of sight when he was out of his room to ensure he did not interact inappropriately with Resident #1. CNA #1 said staff specifically watched for Resident #2's interactions with Resident #1 and Resident #8 since he had been sexually inappropriate with both of them. The SSA was interviewed on 3/11/25 at 11:30 a.m. The SSA said she was unaware of the incidents of inappropriate touching that occurred between Resident #1 and Resident #2. She said she did not know that staff were to monitor Resident #1 to ensure she was kept safe. The assistant nursing home administrator (ANHA) was interviewed on 3/11/25 at 4:37 p.m. The ANHA said Resident #2 was put on ongoing line of sight monitoring when he was out of his room after the 12/18/24 incident (see above). She said all staff were responsible for taking part in monitoring the resident, regardless of discipline, to make sure he did not engage in inappropriate behavior with other residents. (continued on next page)

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F 0600 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Resident #5's baseline care plan, initiated 1/18/25, documented the resident was cognitively impaired. He was unable to understand staff and was unable to communicate easily with staff. The resident was independent with mobility tasks but needed assistance with dressing and grooming. The nursing note, dated 1/21/25 at 5:35 p.m., documented Resident #5 had a change in behavior when he physically assaulted another male resident by hitting him in the face with a strip of folded-up duck tape. The staff were unable to redirect and calm the resident's aggressions so he was discharged to the hospital due to unmanaged aggressive behavior. The note documented since admission, verbal and physical aggression toward other residents and staff had been noted several times. He injured a staff member and was physically combative with another, requiring staff intervention and separation from other residents for their safety. The resident had entered other residents' rooms multiple times, sometimes taking possessions with him upon exiting. At times he entered other residents' rooms and undressed and redressed wearing another resident's clothes. He had physically touched other residents and woke them up from their sleep. Resident #5 lacked understanding and was unable to follow directions or comply with instructions. Resident #5 wandered frequently and had to be redirected several times from heading out an exit door. A wanderguard bracelet was placed on his arm to alert staff of his exit-seeking. The note documented that the resident's spouse said she was afraid of Resident #5 because he had become more paranoid and aggressive toward family members so she was expecting him to be aggressive while at the facility. The nursing note, dated 1/21/25 at 5:29 p.m., documented that at approximately 4:45 p.m., Resident #5 was observed leaning over Resident #6 hitting him with a folded-up piece of duct tape. Resident #5 did not respond to instructions from staff to stop hitting Resident #6. RN #1 had to physically hold and pull Resident #5 away from Resident #6 to stop the assault. The note further documented that when Resident #5 was pulled off of Resident #6, Resident #5 proceeded to stomp and kick the staff. RN #1 held Resident #5's hands so he could not scratch at those near him. RN #1 then placed the resident on the floor and sat behind him so he could hold on to the resident and not get injured while the resident calmed down. Once Resident #5 calmed down, nursing staff assisted him into a wheelchair. Emergency medical services (EMS) and the police were called and the resident was taken to the hospital for evaluation and treatment. D. Staff interviews RN #1 was interviewed on 3/11/25 at 2:00 pm. RN #1 said Resident #5 was confused and aggressive toward staff since he was admitted to the facility. RN #1 said he provided care to Resident #5 on multiple shifts and he was difficult to redirect. RN #1 said Resident #5's aggressive behaviors included verbal threats as well as physical aggression, such as hitting, kicking and pushing staff. RN #1 said on the day of the incident, 1/21/25, he saw Resident #5 pull tape off of the carpet in the hall that was placed there to keep and remind Resident #5 to stay away from another resident's room which he frequently wandered into. (continued on next page)

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	065331	A. Building B. Wing	03/11/2025

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

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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0600 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	RN #1 said when he saw the resident tearing up the tape, he tried to redirect Resident #5, but the resident only became more agitated than he already was and did not follow cues to stop. RN #1 said he went down the hall to inform maintenance that the tape would need to be replaced. He said he heard a commotion and he observed Resident #5 leaning over Resident #6 and he appeared to be hitting Resident #6 repeatedly. He said he responded and separated the residents. He said he told Resident #5 that if did not stop hitting Resident #6 he would pull him away from Resident #6. RN #1 said when Resident #5 did not respond to verbal cues, he felt he was forced to separate the residents physically while the CNA removed Resident #6 from the common area for his safety. RN #1 said additional staff came quickly and got Resident #5 into a wheelchair and he stayed with Resident #5 in the nurse's station until EMS arrived. RN #1 said he was not aware if staff were informed of Resident # 5's aggressive behavior when he was admitted , but Resident #5 was aggressive towards others from the start of his admission. The ANHA was interviewed on 3/11/25 at 4:37 p.m. The ANHA said a staff member was dedicated to screening and coordinating referrals for new residents. She said the facility did not receive the referral for Resident #5 until they had already accepted him. She said the staff were notified of the needs of new residents, including behaviors, in the electronic charting system and a physical report sheet. She said that sometimes the facility did not find out about a resident's behavioral issues until after they were admitted to the facility.