STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	065399	A. Building B. Wing	11/06/2025

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

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0600 Level of Harm - Actual harm Residents Affected - Few	Protect each resident from all types of abuse such as physical, mental, sexual abuse, physical punishment, and neglect by anybody. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on record review and interviews, the facility failed to ensure residents were kept free from abuse for one (#10) of three residents reviewed for abuse out of 11 sample residents.Resident #10 was admitted on [DATE] with diagnoses of autistic disorder, dementia and depression.Resident #11 was admitted on [DATE] with diagnoses of dementia and schizophrenia (mental illness).On 9/7/25, Resident #10 entered the facility from outside. Resident #11 approached Resident #10 and pushed him to the floor. Resident #10 complained of left leg pain and was transferred to the hospital where he was diagnosed with a femur fracture that required surgical repair. Specifically, the facility failed to protect Resident #10 from physical abuse by Resident #11.Findings include:I. Facility policy and procedureThe Resident Rights, dated December 2021, was provided by the nursing home administrator (NHA) on 11/3/25 at 2:30 p.m. It read in pertinent part: Federal and state laws guarantee certain basic rights to all residents. These rights include the right to be free from abuse.II. Incident of physical abuse by Resident #11 towards Resident #10 on 9/7/25The 9/7/25 facility investigation revealed that on 9/7/25 at 11:10 a.m. a staff member observed Resident #10 fall. The investigation revealed the nurse on duty responded. Resident #10 reported he entered the facility from outside, Resident #11 approached him and pushed him down to the floor. The facility staff immediately separated the residents for safety. Resident #10 reported he had pain in his leg and he was transferred to the emergency department for evaluation. Resident #10 was diagnosed with a fractured femur which required surgery to repair the fracture. The investigation documented the NHA interviewed Resident #10 on 9/7/25. Resident #10 said he was very angry about the incident. He said he had not had any previous altercations with Resident #11.The investigation documented Resident #11 was assessed by the nurse and had no injuries. Resident #11 was placed on safety checks for 72 hours. The investigation documented the NHA interviewed Resident #11 on 9/7/25. Resident #11 denied that there had been any conflict with Resident #10 and said he did not do anything to Resident #10. The investigation documented the NHA reviewed camera footage on 9/7/25 and observed Resident #11 push Resident #10 to the floor. The investigation documented that Resident #11 was transferred on 9/8/25 to a new room in the facility, on a different hallway to keep the residents separated. The NHA interviewed four facility residents and they said they had no concerns about physical abuse and said they felt safe at the facility.The investigation documented the facility substantiated the incident of physical abuse. III. Resident #10 (victim)A. Resident statusResident #10, age greater than 65, was admitted on [DATE], discharged to the hospital 9/7/25 and readmitted on [DATE]. According to the November 2025 computerized physician's orders (CPO), diagnoses included fracture of the left femur, autistic disorder, dementia and depression.The 10/6/25 minimum data set (MDS) assessment revealed the resident had moderate cognitive impairments with a brief interview for mental status (BIMS) score 12 out of 15.The assessment documented Resident #10 had no behaviors directed toward himself or others during the assessment period. Resident (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 0600 Level of Harm - Actual harm Residents Affected - Few	#10 required set up assistance/supervision for bed mobility, transfers, walking in his room, hallway, and unit. The assessment identified Resident #10 used a cane or crutch for walking. B. Resident interviewResident #10 was interviewed on 11/5/25 at 2:45 p.m. Resident #10 said he remembered when Resident #11 pushed him to the floor. Resident #10 said Resident #11 approached him as he entered the facility from the outside patio and pushed him, which caused him to fall. Resident #10 said he was upset his femur was fractured and that he had to have surgery. Resident #10 said he was healing and was working towards gaining strength while walking. Resident #10 said he had no concerns and was not afraid of Resident #11 although he was cautious about being pushed by anyone. Resident #10 said there were no previous altercations between himself and Resident #11. C. Record reviewThe behavior care plan, revised 8/21/24, revealed Resident #10 had the potential for verbal aggression. Pertinent interventions included monitoring target behavior (8/21/24), administering medications as prescribed (7/14/24) and redirecting the resident to his room or a calm area (7/14/24).The 9/7/25 nurse progress note revealed Resident #10 yelled out why did you do that. The nurse responded. Resident #10 told the nurse he was pushed by Resident #11 and he fell. The nurse completed an assessment and Resident #10 was transferred to the hospital for evaluation of leg pain.The 9/17/25 nurse progress note revealed Resident #10 returned to the facility with physician's orders for physical and occupational therapy for balance and strengthening.IV. Resident #11 (assailant)A. Resident statusResident #11, age greater than 65, was admitted on [DATE]. According to the November 2025 CPO, diagnoses included dementia and schizophrenia.The 10/6/25 MDS assessment revealed Resident #11 had severe cognitive impairments with a BIMS score of zero out of 15. The assessment revealed Resident #11 had difficulty focusing on attention, had trouble focusing on what was being said and had disorganized thinking. Resident #11 was independent with transfers and ambulationThe assessment revealed Resident #11 had no behaviors towards himself or others during the assessment look-back period. B. Record reviewThe behavior care plan, revised l2/24/23, revealed Resident #11 was at risk for behaviors. Pertinent interventions included redirecting the resident to a safe area and monitoring for safety if he appeared dangerous (2/24/23). The schizophrenia care plan, revised 7/29/24, revealed Resident #11 had a diagnosis of schizophrenia. Pertinent interventions included encouraging the resident to attend and participate in activities or hobbies to increase socialization (7/29/24), providing ongoing evaluation to document mood and medication management (7/29/24) and monitoring and documenting target behaviors (6/6/19).The 9/8/25 progress note documented Resident #11 was moved to a different room. -Review of Resident #11's electronic medical record (EMR) did not reveal documentation regarding the incident on 9/27/25.V. Staff interviewsCertified nurse aide (CNA) #1 was interviewed on 11/5/25 at 3:00 p.m. CNA #1 said she heard Resident #10 and Resident #11 had an altercation. She said Resident #11 pushed Resident #10 to the floor. CNA #1 said she was trained to monitor residents when they were agitated and redirected the residents when necessary. CNA #1 said Resident #10 and Resident #11 enjoyed and participated in activities. She said they had had no behaviors or concerns since the 9/7/25 incident. The NHA was interviewed on 11/5/25 at 12:30 p.m. The NHA said Resident #10 and Resident #11 both had a history of behaviors but not within the previous 12 months. She said Resident #10 had a history of agitation but had an effective care plan. The NHA said Resident #11 had a history of making sexual statements towards others and had not been physically aggressive. The NHA said staff responded appropriately to the incident. She said the residents were assessed and separated and monitored. The NHA said Resident #11 was moved to another hallway in the facility as a precaution. The NHA said Resident #10 returned to the facility and received therapy. The NHA said Resident #10 was almost at his baseline for walking. The NHA said when residents at the facility had a history of behaviors, the staff (continued on next page)

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F 0600 Level of Harm - Actual harm Residents Affected - Few	monitored the residents closely. She said the staff anticipated the resident's needs and redirected residents when necessary to avoid altercations. The NHA said a staff member was in the same room at the time of the incident on 9/7/25. The NHA said Resident #11 pushed Resident #10 as they passed each other near the exit doorway.

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

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F 0684 Level of Harm - Actual harm Residents Affected - Few	reveal documentation regarding the resident's hemorrhoids. -Review of Resident #1's electronic medical record (EMR) did not reveal documentation indicating skin assessments were completed from 10/2/25 to 10/24/25.The 11/1/25 nurse progress note documented Resident #1 complained of hemorrhoid pain and requested to go to bed. The resident's vital signs were taken. The resident's temperature was 97.5 degrees Fahrenheit, heart rate was 56 beats per minute (bpm), respirations were 26 breaths per minute, and blood pressure was 82/48 millimeters of mercury (mmHg) (normal blood pressure is 120/80). The nurse notified the physician of the resident's status and gave an order to have the resident transferred to the emergency department for evaluation. The 11/1/25 emergency department's physician documented Resident #1 reported not feeling well for several days and was sent to the emergency department because his blood pressure was low. The 11/1/25 computerized tomography (CT) scan completed at the emergency department revealed Resident #1 had a 5 centimeter (cm) by 3.7 cm by 4 cm area on her sacrum concerning to be an abscess. Resident #1 was transferred to a higher level of care for a surgical evaluation. The 11/1/25 hospital history and physical revealed Resident #1 was diagnosed with a perianal abscess. The resident required surgical drainage of the abscess and was treated with IV antibiotics. III. Resident #2A. Resident statusResident #2, age greater than 65, was admitted on [DATE] and discharged to the hospital on [DATE]. According to the November 2025 CPO, diagnoses included quadriplegia, acute renal failure, dementia and dysfunctional bladder.The 10/29/25 MDS assessment revealed the resident was severely cognitively impaired with a BIMS score of three out of 15. Resident #2 was dependent on staff assistance for all activities of daily living (ADL). The MDS assessment identified Resident #2 had an indwelling Foley catheter for continuous bladder drainage.B. Hospital nurse interviewThe hospital nurse was interviewed by telephone on 11/4/25 at 10:00 a.m. The hospital nurse said she was working on 11/1/25 when Resident #2 arrived in the emergency room. The hospital nurse said Resident #2 arrived visibly dirty and unkempt. She said the resident had significant skin breakdown on her sacrum and other areas of her body. C. Record reviewThe skin integrity care plan, initiated 10/28/25, revealed Resident #2 had stage 3 pressure wounds prior to admission. Pertinent interventions included completing a skin inspection every seven to 10 days and as needed (10/28/25) and administering medication and treatments per physician orders (10/28/25). The 10/21/25 hospital discharge orders included physician's orders for wound care that included: wound care for the sacrum, cleanse back and sacrum with body wipes and let dry. Apply a thick amount of Triad cream to areas daily and leave the area open to air.The 10/25/25 wound evaluation note read that Resident #2 had an unchanged wound on her buttocks with a plan to continue treatment as ordered.-Review of Resident #2's October 2025 and November 2025 CPO did not reveal physician's orders for wound treatments. -Review of Resident #2's EMR did not reveal documentation indicating the facility assessed the resident's skin after the 10/25/25 wound care note or provided wound care as recommended in the 10/21/25 hospital discharge instructions. IV. Staff interviewsThe DON was interviewed on 11/3/25 at 3:40 p.m. The DON said when a resident was admitted to the facility, the admitting nurse was responsible for reviewing and entering the physician's orders and the hospital discharge instructions. She said if a resident went to an appointment, the nurse on duty was responsible for entering new physician's orders after an outpatient physician appointment. The DON said after new orders were entered, a second nurse was responsible for reviewing the orders and/or instructions for accuracy and completeness. The DON said if a resident was admitted with a need for wound care, the wound care nurse (WCN) was responsible for completing the wound care evaluation and reviewing wound care orders. The DON said the wound care nurse evaluated Resident #2's skin and documented the wound was coated with cream and would reassess the wound after Resident #2 was cleaned/bathed. The DON said that the wound care nurse did not (continued on next page)

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F 0684 Level of Harm - Actual harm Residents Affected - Few	return to complete the wound evaluation and did not verify the wound care orders or initiate a wound care plan of care for Resident #2. The DON said the facility had not provided wound care to Resident #2 during her admission from 10/22/25 to 11/1/25, because they failed to initiate the physician's wound care orders.The WCN was interviewed on 11/6/25 at 4:45 p.m. The WCN said she was unsure why the admitting nurse did not enter physician's orders for wound care for Resident #1. The WCN said after she completed wound evaluations, if there was a need to change wound care orders, she contacted the physician for new orders. The WCN said she forgot to reassess the wounds and to write a baseline care plan for Resident #2's wound care. The DON was interviewed again on 11/4/25 at 11:00 a.m. The DON said Resident #1 had a history of a blister on his buttocks that was healed on 10/2/25. The DON said she was unable to find skin assessments for Resident #1 from 10/2/25 to 10/24/25. The DON said the 10/2/25 skin assessment documented Resident #1 had intact skin and had not complained about hemorrhoid pain until 11/1/25, just before he was transferred to the emergency department. The DON said the nurse assigned to provide care to Resident #1 on 11/1/25 did not assess Resident #1's skin for his hemorrhoid pain prior to his transfer to the hospital due to the resident's changing condition.The NHA was interviewed on 11/5/25 at 12:25 p.m. The NHA said she was aware the wound care orders for Resident #2 were not noted or entered by the nursing staff. The NHA said the facility identified on 11/3/25 (during the survey) that there was a system failure and the wound care orders were missed by the nursing staff. The NHA said she was working with the DON to develop a process and a checklist to ensure nurses reviewed and entered physician's orders into the EMR. The NHA said the policy for skin assessments was that a nurse completed a skin check every seven to 10 days on every resident. The NHA said she was aware the October 2025 skin assessments were not completed for Resident #1. The NHA said she was working with the DON to develop an audit and checklist to ensure skin assessments and documentation were completed according to physician's orders and facility policy.

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

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F 0690 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	output volume of 300 ml of urine emptied from the urine collection bag for the day shift on 10/31/25.Twelve hours later on 11/1/25 at 5:59 a.m. a night shift CNA documented Resident #2 had zero ml of urine emptied from the urine collection bag.-Resident #2 had a total of 300 ml of urine output for the 24-hour period between 10/31/25 at 5:29 a.m. and 11/1/25 at 5:59 a.m. However, the resident's decreased urinary output was not communicated to the nurse or the physician and the resident was not assessed for any complications of urinary retention. The facility was not conducting nurse assessments or monitoring the resident for impaired urinary elimination or urine characteristics (color, odor, clarity) that could indicate a concern regarding the resident's urinary status.On 11/1/25 at 1:50 p.m. the nurse was notified by staff that Resident #2 was not responding or waking up (to verbal stimuli). The nurse assessed Resident #2 and found the resident with respiratory distress, but the resident opened and closed her eyes to physical stimuli. The resident's vital signs were as follows: blood pressure was 159/82 mmHg, heart rate was 131 bpm, respirations were 22 breaths per minute, temperature was 98.6 and oxygen saturation was 75% on room air. The nurse called 911 and the resident was transferred to the hospital emergency department. On 11/1/25 after being evaluated at the emergency department, the resident was admitted to the hospital for encephalopathy and required respiratory intubation for airway protection. The resident's foley catheter was removed and 2000 ml of bloody urine with pus was drained. The CT scan in the emergency department revealed the resident had bilateral hydronephrosis and debris in the bladder. Resident #2 was diagnosed with severe sepsis, acute respiratory failure, and a myocardial infarction, and required placement on a ventilator. Resident #2 was stabilized and transferred to a different hospital's intensive care unit for higher level of care. The director of nursing (DON) was interviewed on 11/1/25 (during the survey) and said the CNAs were expected to notify the nurse when a resident's urine output was low. The DON said when the CNAs performed catheter care they should also check the placement of the urine drainage bag and verify urine was draining from the bladder.Staff interviews on 11/4/25 (during the survey) revealed staff were lacking important knowledge and training in regards to caring for residents that had indwelling foley catheters and those with dysfunctional bladders, as well as the care needs for residents with quadriplegia.B. Facility notification of immediate jeopardyOn 11/5/25 at 12:45 p.m. the NHA was notified of the immediate jeopardy findings for failure to assess Resident #2's Foley catheter patency and monitor urine output.C. Facility plan to remove the immediate jeopardyOn 11/6/25 at 5:40 p.m. the nursing home administrator (NHA) provided a plan to remove the immediate jeopardy situation. The removal plan read:Plan of CorrectionOn 11/5/25, education for all nurses and CNAs on daily catheter care, as well as monitoring and reporting of urinary output, was completed by the DON or designee prior to the next scheduled shift. Nurses were also educated on how to perform bladder assessments for residents with indwelling catheters prior to their next scheduled shift. This education included a special focus on residents who are unable to communicate or who are paralyzed and therefore can not express or feel whether they are emptying their bladders. On 11/5/25, all residents with indwelling catheters were audited for their last catheter change date and ensured accurate physician's orders were obtained for the next catheter change. The electronic medication administration record (eMAR) was reviewed to ensure accurate orders were in place, including those for catheter care, urinary output monitoring and catheter replacement. All residents with indwelling catheters were assessed by the DON for bladder fullness to ensure proper catheter drainage. One additional resident was identified as being affected by this deficient practice. An as needed catheter change physician's order was needed and was added by the DON for the other identified resident. On 11/5/25 a shift evaluation for residents with dwelling catheters was implemented. This evaluation included assessments of bladder status, (continued on next page)

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
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NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Rio Grande Rehabilitation and Healthcare Center	39 Calle Miller LA Jara, CO 81140

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0690 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	urine output, potential blockages and urine characteristics. These evaluations will include new admission and readmissions to be done upon admission and every shift thereafter. These evaluations will be conducted by floor nurses every shift and documented on a User Defined Assessment (UDA) inside the eMAR. The evaluation is named Nursing-Foley Catheter Evaluation. These evaluations will continue for the duration of the resident's indwelling catheter. Abnormal findings from the floor nurse will be reported to the director of nursing and the on-call physician. All new admissions, readmissions, and newly ordered indwelling Foley catheters will be audited by the DON or designee to ensure that catheter insertions are completed in accordance with physician's orders. Additionally, all new admissions with indwelling catheters will be audited by the DON or designee to confirm the presence of appropriate physician orders and nursing interventions for daily catheter care. The audit will be completed five times a week by the director of nursing or Designee. E. Removal of immediate jeopardyOn 11/6/25 at 5:48 p.m. the NHA was notified the immediate jeopardy situation was removed, based on the facility's plan and evidence of its implementation. However, deficient practice remained at a G level, actual harm that was not immediate jeopardy, isolated. II. Facility policy and procedureThe Urinary Catheter Care policy and procedure, undated, was received from the DON on 11/4/25 at 3:15 p.m. It read in pertinent part, The purpose of this procedure is to prevent urinary catheter-associated complications, including urinary tract infections. The procedure is as follows:-Review the resident's care plan to assess any special needs of the resident;-Empty the collection bag at least every eight hours;-Observe the resident's urine level for noticeable increases or decreases. If the level stays the same, or increases rapidly, report it to the physician or supervisor;-Follow the facility procedure for measuring and documenting input and output;-Check the resident frequently to be sure he or she was not lying on the catheter and to keep the catheter and tubing free of kinks;-If the catheter material contributes to obstruction, notify the physician, and change the catheter if instructed to do so;-Catheter irrigation may be ordered to prevent obstruction; and,-Report unusual findings to the physician immediately. The following information should be recorded in the resident's medical record:-All assessment data obtained when giving catheter care;-Character of urine such as color, clarity, and odor;-Any problems noted at the catheter-urethral junction; and,-Any problems or complaints made by the resident.III. Resident #2A. Resident statusResident #2, age greater than 65, was admitted on [DATE] and discharged to the hospital on [DATE]. According to the November 2025 computerized physician orders (CPO), diagnoses included quadriplegia, acute renal failure, dementia and dysfunctional bladder.The 10/29/25 minimum data set (MDS) assessment revealed the resident was severely cognitively impaired with a brief interview for mental status (BIMS) score of three out of 15. Resident #2 was dependent on staff assistance for all activities of daily living (ADL). The MDS assessment identified Resident #2 had an indwelling foley catheter for continuous bladder drainage.B. Hospital nurse interviewThe hospital nurse was interviewed by telephone on 11/4/25 at 10:00 a.m. The hospital nurse said she was working on 11/1/25 when Resident #2 arrived in the emergency room. The hospital nurse said she felt Resident #2's abdomen and it was hard and full. She said when she removed the resident's brief, it was full of blood from leakage around the catheter insertion site. She said when she removed the catheter, there was projectile (forcefully ejected) drainage of 2000 ml of pus and blood from Resident #2's bladder. She said that Resident #2 appeared septic and near death and required a flight for life helicopter ambulance transfer to another hospital for a higher level of care.C. Record reviewThe baseline care plan, initiated on 10/28/25, revealed Resident #2 had an indwelling Foley catheter. Pertinent interventions included monitoring for signs and symptoms of a urinary tract infection, blood in the urine, cloudiness, foul smell, fever, change in mental status (initiated (continued on next page)

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