

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 065119	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 12/10/2025
NAME OF PROVIDER OR SUPPLIER Valley Manor Care Center		STREET ADDRESS, CITY, STATE, ZIP CODE 1401 S Cascade Ave Montrose, CO 81401	

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)
<p>F 0689</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Ensure that a nursing home area is free from accident hazards and provides adequate supervision to prevent accidents.</p> <p>(continued on next page)</p>

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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<p>F 0689</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observations, record review and interviews, the facility to ensure residents were free from accidents or hazards for one (#1) of three residents reviewed for accidents out of three sample residents. Specifically, the facility failed to implement interventions to prevent an elopement for Resident #1, despite identifying the resident at high risk for elopement. Findings include: I. Facility policy and procedure The Wandering and Elopement Policy and Procedure revised November 2016, was provided by the nursing home administrator (NHA) on 10/30/25 at 12:05 p.m. It revealed in pertinent part, This facility promotes the least restrictive environment for all residents while recognizing the potential of residents wandering. This facility will utilize monitoring and alarm systems; sign in and out books on all units and maintain pictures of all residents on their units. This facility will maintain a response plan for implementation in the event of a missing resident. Social services or designee will complete an admission Assessment and an Elopement Risk Assessment prior to admission to the secured unit, and prior to placement of a wander guard. Elopement Risk Assessments will also be completed annually, with significant changes and as needed. Wandering or elopement risk will be identified pre-admission or on admission and on going. II. Incident of elopement for Resident #1 on 8/31/25A. Facility investigation The NHA provided the facility investigation of the 8/31/25 elopement event on 10/30/25 at approximately 10:40 a.m. The investigation revealed the following: The investigation summary documented that on 8/31/25 at approximately 3:15 p.m. Resident #1 was found in a supermarket parking lot approximately 0.2 miles from the facility by certified nurse aide (CNA) #4. The investigation summary documented Resident #1 was last known to be in the facility at approximately 2:00 p.m. The facility was not aware Resident #1 had eloped from the facility until CNA #4 found Resident #1 while the CNA was on break. When CNA #4 found Resident #1, he was talking with two unidentified citizens who were on the phone with the police to report a missing person. CNA #4 called the facility from the supermarket parking lot to inform them of the elopement. CNA #4 stayed with Resident #1 until the police arrived and provided escort back to the facility. The investigation summary documented Resident #1 was assessed to be at his baseline cognition and without injury after the event. The investigation summary documented Resident #1 was placed on one-to-one observation in the short term to keep Resident #1 safe. The facility investigation documented the interventions implemented after the event included audits of the alarm system to ensure door alarms were functioning properly as well as education to nursing staff. The investigation summary documented the resident eloped from the front door of the facility and it was missed because no staff member was present to monitor the front door at the time of the resident's elopement. The investigation documented an interview with CNA #4 on 8/31/25 at 3:45 p.m. CNA #4 said she was driving to the gas station on her break when she spotted a familiar face in the supermarket parking lot. CNA #4 said Resident #1 was talking with a gentleman in the parking lot who was on the phone. When CNA #4 introduced herself, the gentleman told her he was talking with the police dispatcher and the dispatcher wanted to talk with her. CNA #4 said she gave her the information she had and the dispatcher told her to stay with Resident #1 until the police arrived. CNA #4 said she called the facility to inform them about Resident #1 immediately after talking with the dispatcher. When Resident #1 and CNA #4 returned to the facility, CNA #2 assisted with returning Resident #1 to his room so CNA #4 could talk to the nurse assigned to his unit. The investigation documented the last time Resident #1 was seen in the facility prior to the elopement event was by CNA #3 at approximately 1:50 p.m. The investigation documented an interview with CNA #3 on 8/31/25. CNA #3 said she briefly saw Resident #1 in the hallway while approaching the kitchen to pick up a lunch order for the memory care unit. CNA #3 said she did not remember anything unusual about the interaction, she only remembered briefly seeing him in the hallway. The investigation documented CNA #2 was the CNA assigned to Resident #1's hall on the day the elopement event occurred (8/31/25). The facility investigation documented an interview with CNA #2 on 8/31/25. CNA #2 said she remembered she was bathing a resident at the time of Resident #1's elopement. CNA #2 said when the bath was complete, she found out Resident #1 was missing and possibly at the theater next to the local supermarket. CNA #2 said she walked out of the facility to walk to the supermarket when she saw Resident #1 and CNA #4 walking back to the facility with a police officer. The facility investigation did not include a written statement or documented interview with the nurse assigned to Resident #1's hall on the day the elopement event occurred. B. Resident #11. Resident status Resident #1 age greater than 65 was admitted on 10/24/25. According to the October 2025</p>		