STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	065119	A. Building B. Wing	04/09/2026

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Valley Manor Care Center	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)
F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	Provide and implement an infection prevention and control program. Based on observations, record review and interviews, the facility failed to maintain an effective infection prevention and control program to provide a safe, sanitary and comfortable environment to help prevent the development and transmission of disease on two of four units. Specifically, the facility failed to:-Ensure staff used personal protective equipment (PPE) when performing care for residents who were on enhanced barrier precautions (EBP); and, -Ensure staff wore PPE when handling dirty linen. Findings include: I. EBP failures A. Professional reference According to The Centers for Disease Control and Prevention's (CDC) Hand Hygiene for Healthcare Workers (2/27/24), retrieved on 4/14/26 from https://www.cdc.gov/cleanhands/hcp/clinical-safety/index.html, included the following recommendations for hand hygiene, Hand hygiene protects both healthcare personnel and patients. Cleaning your hands reduces the potential spread of germs, including those resistant toantibiotics. Clean your hands immediately before touching a patient and after touching a patient or the patient's surroundings. B. Facility policy and procedure The EBP policy, undated, was received from the infection preventionist (IP) on 4/9/25 at 1:20 p.m. The policy read in pertinent part, The policy of the facility on Enhanced Barrier Precautions, in addition to standard and contact precautions will be implemented during the high - contact resident care activities when caring for residents have an increase risk for an acquired a multi-drug resistant organisms (MDRO) such as a resident with a wound, an indwelling medical device or a resident with an infection. EBP refers to an infection control intervention designed to reduce transmission of multi drug-resistant organisms that employs targeted gown and glove use during high contact resident care activities. The purpose of EBP was to prevent opportunities to transfer MDROs to employees hands and clothing during care beyond the situation in which staff anticipate exposure to blood or body fluids. (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 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	Personal protective equipment was required for all staff providing high content resident care to include gown and gloves with: dressing, bathing/showering, transferring, providing hygiene, changing linens, changing briefs or assisting with toileting, device care or use: of a central line, urinary catheter, feeding tube or tracheostomy and wound care of any skin opening requiring a dressing. C. Observations On 4/7/26 at 3:30 p.m. CNA #7 and CNA #8 entered Resident #74's room. Resident #74's door had a sign on the door to indicate Resident #74 required EBP with high contact care. CNA #7 and CNA #8 did not don a gown upon entering the room. CNA #7 and CNA #8 transferred Resident #74 to wheelchair including moving Resident #74's indwelling urinary catheter tubing and collection bag to the wheelchair. CNA #7 assisted Resident #47 out of their room while CNA #8 Resident #74's personal items out to a transport van. On 4/8/26 at 4:11 p.m. CNA #7 and CNA #8 entered Resident #8's room. Resident #8's door had a sign on the door to indicate Resident #8 required EBP with high contact care. CNA #7 and CNA #8 transferred Resident #8 with a Hoyer lift. CNA #7 and CNA #8 did not don a gown while transferring Resident #8 via hoyer lift; including the handling of Resident #8's indwelling urinary catheter and collection bag. On 4/8/26 at 4:12 p.m. RN #2 responded to the call light for Resident #48. Resident #48's door had a sign on the door to indicate Resident #48 required EBP with high contact care. RN #2 did not don a gown while assisting Resident #48 in the bathroom. On 4/9/26 at 9:33 a.m. CNA #1 and CNA #2 entered Resident #8's room. Resident #8's door had a sign on the door to indicate Resident #8 required EBP with high contact care. CNA #1 and CNA #2 did not don a gown while transferring Resident #8 from his recliner to his wheelchair via Hoyer lift; including the handling of Resident #8's indwelling urinary catheter and collection bag. D. Staff interview CNA #1 was interviewed on 4/9/26 at 9:43 a.m. CNA #1 said she completed video education on the computer as well as inservice training on EBP guidelines. CNA #1 said the amount of PPE she wore depended on the task the resident required. CNA #1 said she always wore a gown and gloves when emptying the catheter of a resident on EBP precautions. CNA #1 said she always wore gloves, but not a gown when completing transfers, incontinence cares, or bathing residents. E. Additional observations On 4/7/26 at 4:15 p.m. certified nurse aide (CNA) #4 was assisting Resident #45 in his room. CNA #4 assisted the resident in changing his brief while the resident lifted his bottom off the bed. CNA #4 did not don (put on) gloves or a gown. There was a sign hung on the door of the room that indicated the resident was on EBP. EBPs. F. Additional staff interviews CNA #4 was interviewed on 4/7/26 at 6:14 p.m. CNA #4 said Resident #45 needed assistance to change his brief, but the resident just lifted his bottom up so he could exchange the soiled brief with a clean brief. He said he usually only wore gloves and he wore a gown and gloves when he assisted him (continued on next page)

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F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	into the shower. He said he knew EBP precautions were put in place when someone needed an extra layer of protection from an infection or a disease. The IP was interviewed on 4/9/26 at 12:05 p.m. She said the facility's EBP policy stated to wear gown and gloves with high contact care such as bathing, changing, linen transfers, indwelling catheters and wounds. She said a sign was placed on the resident's door to alert the staff on what to wear. She said she had not had a formal education class with the staff yet and was in the process of setting up walking rounds with staff to show them how to don and doff (take off) for EBP precautions. II. Laundry failures A. Facility policy and procedure The Handling Linens to Prevent and Control Infection policy, undated, was received from theIP on 4/9/25 at 1:20 p.m. It read in pertinent part, It was the policy of the facility, linens (laundry) would be handled, stored, processed, and transported in a manner to prevent the spread of infection. All potentially contaminated linen to be handled with appropriate measures to prevent cross-transmission. All staff should follow standard precautions when handling all used linen which was potentially contaminated (gloves, gown when sorting and rinsing). B. Observations On 4/8/26 at 1:40 p.m. laundry assistant #2 was loading dirty linen into the washing machine. She wore one glove on her right hand, which did not cover her entire hand. She used her right hand to handle the linens from a laundry bin. She pushed the linen into the machine which touched her wrist, forearms and left ungloved hand. C. Staff interviews Laundry assistant #1 was interviewed on 4/8/26 at 1:48 p.m. Laundry assistant #1 said soiled linen was brought into the laundry room in a sugar bag (dissolvable bag), which was put right into the washing machine. She said PPE was used with soiled linen. She reached high into a cabinet and pulled down a container of gowns. She said there was a reusable gown on the back of the door in the soiled linen room. The IP was interviewed on 4/9/26 at 12:05 p.m. The IP said PPE was worn when handling visibly soiled linens. She said it was standard of practice to wear gloves when handling soiled linens. She said there was a risk of cross contamination without PPE.

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F 0550 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Honor the resident's right to a dignified existence, self-determination, communication, and to exercise his or her rights. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observations, record review and interviews, the facility failed to provide care to each resident with respect and dignity and care for each resident in a manner and in an environment that promotes maintenance or enhancement of his or her quality of life for four (#3, #6, #55, #61) of eight residents reviewed of 36 sample residents.Specifically, the facility failed to respond to call lights in a timely manner to provide care with dignity for Resident #3, Resident #6, Resident #55 and Resident #61. Findings include:I. Facility policy and procedureThe Call Light, Use of Resident Call System policy, revised October 2021, was provided by the assistant director of nursing (ADON) on 4/9/26 at 5:55 p.m. It read in pertinent part, All facility personnel must be aware of call lights at all times. Answer ALL call lights promptly whether or not you are assigned to the resident. For bedside call lights, a light and a sound will appear and be heard over the door of the resident's room and on the board at the nursing station. For emergency call lights in bathrooms, shower and tub rooms, a light and a continuous sound will appear over the door of the room and on the board at the nursing station. Answer call lights in a prompt, calm, courteous manner; turn off the call light as soon as you enter the Room. Never make the resident feel you are too busy to give assistance; offer further assistance before you leave the room. When providing care to residents be sure to position the call light conveniently for the resident to use. Tell the resident where the call light is and show him/her how to use the call light. Quality assurance and assessment program to check the call light system at regular intervals per the manufacturer's recommendations.II. Resident #3A. Resident statusResident #3, age greater than 65, was admitted on [DATE]. According to the April 2026 computerized physician orders (CPO), diagnoses included cerebral infarction affecting the left non-dominant side, hemiplegia and hemiparesis (weakness and loss of function of one side of the body), unspecified convulsions, chronic pain, muscle weakness, depression, dysphagia, carpal tunnel syndrome, paresthesia of the skin (pins and needles) and hypertension.The 3/18/26 minimum data set (MDS) assessment revealed Resident #3 was cognitively intact with a brief interview for mental status (BIMS) score of 14 out of 15. Resident #3 was dependent on staff for putting on footwear, toileting, oral hygiene and bathing. Resident #3 required substantial assistance with personal hygiene, upper and lower body dressing. Resident #3 had functional limitations to range of motion to the left upper and lower extremities.B. Resident interviewResident #3 was interviewed on 4/6/26 at 2:56 p.m. Resident #3 said it usually took a while for staff to respond to call lights. He said he did not even expect a response for at least 10 to 15 minutes. He said he frequently waited more than 20 or 30 minutes for assistance. Resident #3 said he sometimes had to yell for help. Resident #3 said he was not typically incontinent of bowel. He said one time he waited so long for someone to respond to his call light, he was incontinent of bowel in his bed. Resident #3 said he felt frustrated and embarrassed when he could see his bathroom from his bed, but needed to be cleaned up because no one could help him in time. Resident #3 said he observed the same thing happen to his previous roommate.III. Resident #6A. Resident statusResident #6, age greater than 65, was admitted on [DATE]. According to the April 2026 CPO, diagnoses included coronary artery disease, hypertension, diabetes, non-alzheimer's dementia, depression, asthma, carpal tunnel syndrome and dysphagia.The 3/6/26 MDS assessment revealed Resident #6 was cognitively intact with a BIMS score of 14 out of 15. Resident #6 required substantial assistance with toileting and moderate assistance with bathing. Resident #6 required set up assistance with footwear, upper and lower body dressing and personal hygiene. Resident #6 ambulated with a walker or wheelchair.B. Resident interviewResident #6 was interviewed on 4/6/26 at 4:14 p.m. Resident #6 said she frequently waited over 20 minutes for assistance after pressing her call light. Resident #6 said both her and her roommate have had to wait up to a half an hour for assistance in the bathroom, sometimes having to yell for help. Resident #6 said having to wait so long felt very frustrating, and (continued on next page)

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F 0550 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	long wait times seemed to happen frequently at any time of the day.IV. Resident #55A. Resident statusResident #55, age greater than 65, was admitted on [DATE]. According to the April 2026 CPO, diagnoses included orthostatic hypotension, protein-calorie malnutrition, depression, anxiety, dysphagia, restless leg syndrome, insomnia and Gastro-esophageal reflux disease (GERD) .The 2/5/26 MDS assessment revealed Resident #6 was cognitively intact with a BIMS score of 15 out of 15. Resident #55 was dependent on staff for all transfers, bathing, toileting, personal hygiene, footwear, upper and lower body dressing. Resident #6 used a wheelchair for mobilityB. Resident interviewResident # 55 was interviewed on 4/7/26 at 9:45 a.m. Resident #55 said when she first moved into the facility, it felt like twice as many staff worked on the unit. Resident #55 said she frequently waited 20 to 30 minutes for assistance after pressing her call light. Resident #55 said the staff forgot to give her a shower last Sunday(4/5/26). Resident #55 said a certified nurse aide (CNA) offered her the choice to complete a bath before or after breakfast. Resident #55 said she told the CNA she preferred after breakfast, but the CNA never came back. Resident #55 said when she asked later in the day, the staff told her they did not have time any more. Resident #55 said she felt bad for the staff, she said she felt the staff were asked to do twice as much with only half the help. V. Resident #61A. Resident statusResident #61, age greater than 65, was admitted on [DATE]. According to the April 2026 CPO, diagnoses included hypertension, non-alzheimer's dementia, depression, sleep apnea, atrial fibrillation, abnormal gait and history of falls.The 1/23/26 MDS assessment revealed Resident #6 had moderate cognitive impairment with a BIMS score of nine out of 15. Resident #6 required supervision or touching assistance with toileting and bathing. Resident #6 was independent with all other activities of daily living. B. Resident interviewResident #61 was interviewed on 4/8/26 at 9:57 a.m. Resident #61 said she experienced long call light wait times. Resident #61 said she had to wait over twenty minutes for assistance after using the call light multiple times. Resident #61 said it could happen at any time, but seemed to happen most often during the night. Resident #61 said sometimes staff would enter to turn off the light at a reasonable time, but then leave and not come back to assist with what she called for in over an hour. Resident #61 said she remembered an instance where she had to scream for help from the toilet. VI. ObservationsOn 4/6/26 at 12:07 p.m. the call light for room [ROOM NUMBER] was activated, staff did not respond to the call light for 18 minutes. On 4/7/26 at 9:22 a.m. the call light for room [ROOM NUMBER] was activated, staff did not respond to the call light for 26 minutes.VII. Record reviewAn audit of call light response times from 3/25/26 through 4/8/26 was provided by the social services director (SSD) on 4/8/26 at 6:36 p.m. Review of the call light response log from 3/25/26 to 4/8/26 revealed the following call light response times:The call light was activated and not answered for 15 to 20 minutes 71 timesThe call light was activated and not answered for 20 to 30 minutes 59 times.The call light was activated and not answered for 30 to 40 minutes 13 times.The call light was activated and not answered for 40 to 50 minutes six times.The call light was activated and not answered for 50 minutes or longer seven times.The majority of call light response times 15 minutes or longer occurred from the hours of 12:00 a.m. to 12:00 p.m., establishing a pattern of prolonged call light response time during the morning hours.A grievance form related to long call light wait times, dated 12/15/25, was provided by the SSD on 4/9/26 at 5:44 p.m. A grievance was filed by a discharged resident and Resident #30 related to long call light wait times over the previous weekend. The grievance form revealed an audit of call light response times was completed and acknowledged call light wait times of 20 to 40 minutes. The grievance form documented staff were provided in-person education on the call light policy and procedure as correction action resulting from the grievance. VIII. Staff interviewsCNA #1 and CNA #2 were interviewed together on 4/9/26 at 10:04 a.m. CNA #1 said they usually had two CNAs for each hall, but if someone called off they would move a CNA from the rehabilitation unit to one of the other units to cover. CNA #1 said the facility used to have a CNA who was dedicated to giving residents baths. CNA #1 said she did not know why but the position went away and was not replaced. CNA #1 and CNA #2 both said they were responsible for answering the (continued on next page)

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F 0550 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	call lights as well as providing baths to all residents who have a bath scheduled that day for their hall. CNA #2 said they decided between them who wants to provide baths for which residents, and do their best to meet each resident's preferred bath time. CNA #1 said it was difficult to answer all of the call lights in a timely manner when one CNA is off the floor bathing a resident. CNA #2 said sometimes residents had been frustrated due to long wait times baths or around meal times, but the residents usually understood that they may need to wait during busy times of the day.The nursing home administrator (NHA) and the director of nursing (DON) were interviewed together on 4/9/26 at 3:41 p.m. The NHA said when they first received the call light system with the ability to audit call light response times, they would perform routine audits regularly, but she had not completed a full audit recently. The DON said the call light response time did not describe why the resident was calling or what the circumstances were during the time of the call light. The DON said she knew sometimes the CNA would leave the light one because they needed additional assistance from the floor nurse. The NHA and the DON said they would not want a resident to wait longer than 15 minutes for assistance unless unexpected circumstances occurred requiring staff to respond, like a fall or change in condition. The NHA said they were not aware of any grievances related to call light response time so far this year, but residents previously filed occasional complaints. The DON said sometimes they would audit call light response times after receiving a complaint from a family member, reporting they were on the phone with the resident while the resident pressed their call light and waited over an hour for a response. The NHA said with each complaint, they would complete an audit of the reported time frame to confirm the call light response time and provide corrective education if needed, or ensure the residents call light functioned correctly. The NHA said she was able to briefly review the call light audit requested during the survey. The NHA said she saw an increased wait time during the busiest times of the day. However, the NHA and DON said they were not aware that instances of call light response times over 30 minutes were occurring almost every day. The DON and the NHA said they were also not aware of the pattern of prolonged call light response times; primarily in one hall in the morning until the time of the interview. The NHA said they planned to complete an in depth investigation to identify the root cause for prolonged response times. The SSD was interviewed on 4/9/26 at 5:41 p.m. The SSD said she attended all resident council meetings to take notes as well as assist residents with filing grievances or addressing concerns mentioned in the meeting. The SSD said she remembered a previous resident wanted to file a grievance related to long call light response times during the December 2025 resident council meeting. The SSD said the previous resident reported long wait times up to 30 minutes and reported watching several staff on their phone while residents waited for assistance. The SSD said when the previous resident expressed her concern, Resident #30 voiced the same concerns. The SSD said She reviewed a call light audit with the NHA to investigate the grievance. The SSD said she found call light response times ranging from 20 to 40 minutes at various times on each unit during the weekend. The SSD said the NHA was aware of the grievance and call light audit. The SSD said she also reviewed the call light audit requested during the survey and saw each hall continued to have call light wait times over 20 minutes.

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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 0583 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Keep residents' personal and medical records private and confidential. Based on observations, interviews and record review, the facility failed to keep medical information confidential for one (#20) of one resident out of 36 sample residents.Specifically, the facility failed to ensure Resident #20's medical information was not located in the state survey findings binder in the front lobby of the facility where the public had access to it. Findings include:1. Facility policy and procedureThe Resident Rights policy, revised 4/25/25, was provided by the assistant director of nursing (ADON) on 4/9/26 at 5:55 p.m. It read in pertinent part, Resident rights include, but are not limited to the following categories, each of which is addressed in separate organizational policies: Right to be informed of and participate in treatment, right to choose attending physician, right to be treated with respect and dignity, right to self-determination, right to information and communication, right to privacy and confidentiality, right to a safe environment, right to voice grievances, right to protection from abuse, neglect, and exploitation, discharge, transfer, and appeal rights, financial rights and responsibilities.II. ObservationsOn 4/8/26 at 1:58 p.m. Resident #20's face sheet (a sheet including personal medical information including diagnoses) and medication list were found in the facility's state survey results binder in the front lobby of the facility. Resident #20's face sheet and medication list were behind the most recent survey results, dated 12/10/25.III. Staff interviewsThe nursing home administrator (NHA) was interviewed on 4/8/26 at 2:12 p.m. The NHA said she was surprised Resident #20's face sheet and medication list were found in the state survey findings binder. The NHA said only three staff members updated the state survey findings binder; the regional quality assurance coordinator, the director of nursing (DON) and herself. The NHA said the last time she remembered reviewing or updating the binder herself was May 2025. The NHA said she thought the last person to update the binder was the regional quality assurance coordinator with the new results in December 2025. The NHA said the face sheet and medication list for Resident #20 must have been sitting on the printer when the regional quality assurance coordinator printed the survey results. The NHA said must have not have noticed she grabbed both the survey results and Resident #20's documents and added both to the binder. The NHA said she removed Resident #20's face sheet and mediation list from the state survey findings binder. The NHA said she planned to review the rest of the binder to make sure no other residents personal health information was included in the binder. The NHA said she also planned to talk with the DON and the regional quality assurance coordinator to find out why Resident #20's personal health information was accidentally placed in the binder. The NHA said the face sheet and medication list in the front lobby was a possible Health Insurance Portability and Accountability Act (HIPAA) violation, and a resident's private information cannot be shared with anyone the resident did not consent to share information with.The NHA and the DON were interviewed together on 4/9/26 at 3:41 p.m. The NHA said she called the regional quality assurance coordinator and she confirmed that she likely accidentally included Resident #20's face sheet and medication list when updating the binder in December 2025. The DON said she spoke with the NHA about the situation on 4/8/26. The DON said they planned to change the procedure by having only the NHA and the DON update the binder and for updates to be reviewed by each of them prior to placing the state survey results binder back in the lobby to ensure no other residents personal health information was accidentally included in the binder.

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F 0600 Level of Harm - Minimal harm or potential for 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 observations, record review and interviews, the facility failed to ensure residents were kept free from physical abuse for one (#7) of four residents reviewed for abuse out of 36 sample residents. Specifically, the facility failed to:-Protect Resident #7 from physical abuse by Resident #70; and,-Protect Resident #7 from physical abuse by Resident #64. Findings include:I. Facility policy and procedure The At-Risk Adult Mistreatment Reporting, Investigation and Response policy, dated 3/2/26, was provided by the assistant director of nursing (ADON) on 4/9/26 at 5:35 p.m. The policy read in pertinent part, The policy establishes the commitment to protect the safety, dignity, and well-being of at-risk adults by defining requirements to identify, report, investigate, and respond to suspected mistreatment in accordance with Colorado regulations. To ensure compliance with the mandated report obligations, promotes prompt protective actions, and outlines procedures for internal investigation, administrative follow-up, and staff responsibilities to support resident or participants safety and quality of care. The policy addresses both the organizational report responsibilities of the facility's programs and the individual obligations of staff as mandated reporters under state law. Ensuring resident or participant safety. Upon awareness of a suspected maltreatment, staff will immediately take all necessary actions to protect the resident or participant from further harm.This includes the removal of the alleged perpetrator from contact with the resident or participant when appropriate, provide necessary medical care, ensure supervision, and address any environmental or systemic risks that may pose immediate jeopardy.II. Incident of physical abuse by Resident #70 towards Resident #7 on 2/17/26A. Facility investigation The 2/17/26 facility investigation was provided by the director of nursing (DON) on 4/8/26 at 11:00 a.m.The investigation revealed Resident #70 came up behind Resident #7, grabbed her neck, pushed and slapped her, which caused a superficial wound to the jawline. The staff members who witnessed the event were interviewed and confirmed Resident #70 had ambushed Resident #7 from behind. The nurse on duty was not in the unit at the time. Other residents were interviewed but none observed the incident. The facility determined the behavior was new for Resident #70 and implemented one-to-one monitoring as an intervention. The investigation documented it was recommended to keep the residents separated by at least six feet as much as possible.The investigation documented the residents were unable to provide information regarding the incident due to their cognitive status. The investigation documented monitoring was completed for both residents. The residents' physicians and responsible parties were notified. The investigation documented the facility substantiated the physical abuse.B. Resident #7 (victim)1. Resident status Resident #7, age [AGE], was admitted on [DATE]. According to the April 2026 computerized physician orders (CPO), diagnoses included Lewy body dementia with mood disturbance, anxiety and depression. The 1/26/26 minimum data set (MDS) assessment revealed the resident was severely cognitively impaired with a brief interview for mental status (BIMS) score of one out of 15. She required maximum assistance with activities of daily living (ADL).2. Record review The vulnerability care plan, dated 8/18/25, revealed Resident #7 was at risk for abuse as she had dementia and communication deficits. Interventions included observing the resident to minimize and prevent re-occurrence. The skin assessment, dated 2/19/26, revealed Resident #7 sustained a superficial scratch to the right side of the jaw line less than one inch in size from the 2/17/26 incident.C. Resident #70 (assailant) 1. Resident statusResident #70, age [AGE], was admitted on [DATE]. According to the April 2026 CPO, diagnoses included dementia with severe agitation and behavioral disturbances, and depression. The 3/19/26 MDS assessment revealed the resident was severely cognitively impaired with a BIMS score of zero out of 15. She required maximum assistance with ADLs. The assessment documented the resident displayed verbal and physical behaviors towards others 2. Record reviewThe behavior care plan, dated 10/7/24, documented Resident #70 had (continued on next page)

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	065119	A. Building B. Wing	04/09/2026

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Valley Manor Care Center	1401 S Cascade Ave Montrose, CO 81401

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F 0600 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	behavior problems with verbal and physical aggression towards staff and other residents, to include tendencies to ambush residents. Interventions included keeping the resident six feet away from Resident #7 as much as possible. A progress note, dated 2/19/26, documented Resident #70 attempted to grab Resident #7 by the back of her neck and slapped her on the side of her face. A superficial scratch was noted to Resident #7's jawline less than one inch in size.The residents were separated as soon as the incident occurred.III. Incident of physical abuse by Resident #64 towards Resident #7 on 4/7/26A. ObservationsOn 4/7/26 at 4:05 p.m. Resident #64 was in the common area. Resident #64 was sitting in a recliner and had her walker in front of her, yelled and moved her walker away from Resident #7, who was standing over her. Certified nurse aide (CNA) #5 and an activity assistant (AA) intervened and separated the residents immediately. B. Facility investigationThe 4/7/26 initial investigation was provided by the DON on 4/9/26 at 11:30 a.m. The investigation revealed Resident #7 attempted to take a blanket from Resident #64. In response, Resident #64 slapped Resident #7's hand. Resident #7 attempted to retaliate physically, however the staff promptly intervened and prevented further escalation of the incident. The investigation documented no physical injuries or emotional distress were noted. Both residents were safely redirected away from one another by staff and were currently under close observation by staff and would continue to be kept separated. C. Resident #7 (victim)1. Record reviewA progress note, dated 4/7/26, documented there was a resident-to-resident altercation on 4/7/26. The note documented Resident #7 was evaluated for injuries. The medical director, family and appropriate staff were notified. The skin assessment, dated 4/7/26, revealed no skin injuries from the 4/7/26 incident. D. Resident #64 (assailant)1. Resident status Resident #64, age greater than 65, was admitted on [DATE]. According to the April 2026 computerized physician orders (CPO), diagnoses included dementia without behaviors, anxiety, and depression. The 1/29/26 MDS assessment revealed the resident was severely cognitively impaired with a BIMS score of two out of 15. She required maximum assistance with ADLs. The assessment indicated the resident had no behaviors. 2. Record review A progress note, dated 4/7/26, documented there was a resident-to-resident altercation on 4/7/26. The note documented Resident #64 was evaluated for injuries. The medical director, family and appropriate staff were notified. The vulnerability abuse prevention care plan, dated 10/23/25, documented Resident #64 wandered into other residents' rooms. The care plan documented when the resident displayed persistent or inappropriate behaviors, staff should remove the resident to an area away from others.IV. Staff interviewsThe activity assistant (AA) was interviewed on 4/7/26 at 6:00 p.m. The AA said she redirected the resident away from each other when they were too close together. The AA said Resident #7 touched other residents' things and she had to redirect the resident away from others often. CNA #4 was interviewed on 4/7/26 at 6:14 p.m. CNA #4 said Resident #7 fiddled with and moved items around the facility. CNA #4 said Resident #7 went into other residents' rooms and spaces. He said he kept an eye on all the residents to keep them safe from a possible altercation. CNA #5 was interviewed on 4/8/26 at 3:30 p.m. CNA #5 said the residents who resided in the memory care unit were hard to redirect. She said Resident #7 wandered around the unit most of the day, getting into other residents' things. She said she tried to keep an eye on Resident #7. She said she often found herself in between residents to stop them from hitting each other. Licensed practical nurse (LPN) #1 was interviewed on 4/8/26 at 3:46 p.m. LPN #1 said when residents had an altercation, they were separated, a skin check was completed and the DON was notified. She said the staff would monitor the resident and keep an eye on them so they did not touch each other. The DON was interviewed on 4/8/26 at 4:30 p.m. The DON said allegations of abuse were reported when they occurred and a full investigation was started. The DON said the staff monitored the residents closely and redirected them when needed. She said Resident #70 ambushed Resident #7 from behind on 2/17/26. She said the staff intervened right away and a one-to-one caregiver was assigned to Resident #70. The DON said the staff were educated to have line of sight for residents when they were in the common area. The DON said the interventions for the victim of the alleged abuse were not (continued on next page)

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	065119	A. Building B. Wing	04/09/2026

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Valley Manor Care Center	1401 S Cascade Ave Montrose, CO 81401

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F 0600 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	usually updated. She said she recently started looking at placing interventions for both residents involved in altercations.The DON said since the incident of abuse between Resident #7 and Resident #64 on 4/7/26, the interdisciplinary team (IDT) had discussions about new interventions for Resident #7 because of her risk of wandering. She said as of today (4/8/26), Resident #7's care plan was updated to have her not sit by Resident #64. The DON said education had been completed with new approaches in the memory care unit after the second incident on 4/7/26.

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	065119	A. Building B. Wing	04/09/2026

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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 - Few	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 two (#21 and #44) of five residents were free from chemical restraints and were receiving the least restrictive approach for their needs out of 36 sample residents. Specifically, the facility failed to follow up on the pharmacist's recommendations for a gradual dose reduction recommendations (GDR) for Resident #21 and Resident #44 for two months. Findings include:I. Facility policy and procedureThe Unnecessary Medication, Psychotropic Medication and Gradual Dose Reduction policy was provided by the director of nursing (DON) On 4/9/26 at 5:35 p.m. The policy read in pertinent part, The purpose of this policy is to ensure that all medications prescribed and administered withinthe long-term care and skilled nursing facilities are clinically appropriate, evidence-based, and aligned with each resident's individualized needs, preferences, and goals of care. The policy outlines expectations for identifying and preventing unnecessary medication use, ensuring the safe and appropriate use of psychotropic medications, and implementing gradual dose reduction strategies when clinically indicated. Residents who use psychotropic drugs will receive a GDR and behavioral interventions, to be managed at lower doses or to discontinue these drugs. Within one year of a resident's admission on a psychotropic medication or after a practitioner has initiated a psychotropic medication, the facility will attempt a GDR in two separate quarters with at least one month between attempts, unless clinically contraindicated. After the first year, a GDR will be attempted annually, unless clinically contraindicated. Opportunities during the care process to consider whether the medication should be continued, reduced, or discontinued, or otherwise modified include: during the monthly drug regimen review by the pharmacist, when the physician or prescribing practitioner evaluates the resident's progress and during the quarterly MDS (minimum data set) review by the interdisciplinary team. GDRs will be documented in the resident's medical record in accordance with facility protocols.II. Resident #21 A. Resident statusResident #21, age greater than 65, was readmitted on [DATE]. According to the April 2026 computerized physician orders (CPO), diagnoses included chronic obstructive pulmonary disease (COPD), anxiety and dysphagia. The 3/12/26 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. She required maximum assistance with her activities of daily living (ADL). B. Record reviewThe psychotropic medication care plan, dated 11/29/21, revealed Resident #21 was seen by behavioral health services. Pertinent interventions included evaluating the resident for changes in behavior, mood or anxiety level prior to use of or dose change for psychoactive medication.The pharmacy consultant recommendation, dated 12/9/25, documented the pharmacist recommended to attempt a GDR to 30 milligrams (mg) one time a day for the medication duloxetine (antidepressant) or complete a clinical contraindication. Review of Resident #21's February 2026 CPO revealed the following physician's order:Duloxetine 60 milligrams, one tablet by mouth two times a day, ordered on 6/17/24 and discontinued on 2/10/26.Review of Resident #21's April 2026 CPO revealed the following physician's order:Duloxetine 30 milligrams, one tablet by mouth one time a day, ordered on 2/10/26. -Review of Resident #21's electronic medical record (EMR) revealed the facility failed to address the pharmacist's recommendation (from 12/9/25) for approximately two months.III. Resident #44A. Resident status Resident #44, age [AGE], was readmitted on [DATE]. According to the April 2026 CPO, diagnoses included chronic obstruction pulmonary disease (COPD), dementia and depression. The 2/9/26 minimum data set (MDS) assessment revealed the resident was severely cognitively impaired with a BIMS score of one out of 15. She required maximum assistance with her ADLs. B. Record review The psychotropic medication care plan, dated 4/6/23, revealed Resident #44 had anxiety with mood disturbances,visual hallucinations, restlessness and agitation. Pertinent interventions included notifying the medical director of recommendations for dose reduction trials or (continued on next page)

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	065119	A. Building B. Wing	04/09/2026

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Valley Manor Care Center	1401 S Cascade Ave Montrose, CO 81401

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F 0605 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	other pharmacist findings. The pharmacy consultant recommendation, dated 12/9/25, documented the pharmacist recommended to attempt a GDR to 30 mg one time a day for the medication duloxetine or complete a clinical contraindication. Review of Resident #44's February 2026 CPO revealed the following physician's order:Duloxetine 60 milligrams, one tablet by mouth at bedtime, ordered on 6/12/25 and discontinued on 2/6/26.Review of Resident #44's April 2026 CPO revealed the following physician's order:Duloxetine 30 milligrams, one tablet by mouth one time a day, ordered on 2/6/26. -Review of Resident #44's EMR revealed the facility failed to address the pharmacist's (from 12/9/25) recommendation for approximately two months.IV. Staff interviews The DON was interviewed on 4/9/26 at 4:30 p.m. The DON said the pharmacist made recommendations for residents' medications monthly. She said she then reviewed the recommendations and contacted the medical director to make the changes. She said most responses from the provider were within 30 days, but she had made several attempts to contact certain providers for the recommendations. She said she had difficulties ensuring Resident #21 and Resident #44's provider responded timely to pharmacy requests. V. Facility follow-upAn email was received by the DON on 4/10/26 at 3:49 p.m. The email revealed a fax confirmation showing the provider was first notified on 12/17/25 at 2:44 p.m. and 5:09 p.m.-The fax confirmation did not indicate which resident the provider was notified about. The email documented a second request was made on 2/6/26 at 8:25 a.m. for Resident #21's GDR review. -However, there was no documentation to show specific requests for medication modification for the GDR recommendations for Resident #44.

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	065119	A. Building B. Wing	04/09/2026

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F 0609 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Timely report suspected abuse, neglect, or theft and report the results of the investigation to proper authorities. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on record review and interviews, the facility failed to timely report an allegation of abuse involving three (#43, #39 and #76) of five residents reviewed for abuse out of 36 sample residents.Specifically, the facility failed to-Timely report allegations of abuse by licensed practical nurse (LPN) #3 towards Resident #43;-Report allegations of abuse by LPN #3 towards Resident #39; and, -Report allegations of abuse by the occupational therapist (OT) towards Resident #76. Findings include:I. Facility policy and procedureThe Abuse, Neglect, Exploitation or Misappropriation - Reporting and Investigating policy, initiated 3/2/26, was provided by the nursing home administrator (NHA) on 4/9/26 at 5:35 p.m. It read in pertinent part, This policy establishes (the facility's) commitment to protecting the safety, dignity, and well-being of at-risk adults by defining requirements for identifying, reporting, investigating, and responding to suspected mistreatment in accordance with Colorado regulations. (The facility) will ensure that all suspected mistreatment of at-risk adults is reported, investigated, and responded to in accordance with this policy, federal requirements, and Colorado regulations. All staff are required to report suspected mistreatment, cooperate with investigative processes, and support actions that protect resident/participant safety, without fear of retaliation. Any (facility) employee or volunteer who has reason to believe that an at-risk adult has been mistreated or is at imminent risk of mistreatment will immediately report this concern to their supervisor, Administrator/Executive Director, or designee. II. Allegation of verbal and physical abuse by LPN #3 towards Resident #43 A. Resident #43 (alleged victim)1. Resident statusResident #43, age greater than 65, was admitted on [DATE]. According to the April 2026 computerized physician orders (CPO), diagnoses included adult failure to thrive, chronic atrial fibrillation unspecified and kidney disease stage three. According to the 4/7/26 minimum data set (MDS) assessment, Resident #43 had moderate cognitive impairment with a brief interview for mental status (BIMS) score of 10 out 15. The MDS assessment indicated Resident #43 used a walker for mobility and required partial to moderate assistance for dressing. According to the MDS assessment, Resident #43 did not have physical or behavioral systems directed to others. 2. Resident interview Resident #43 was interviewed on 4/7/26 at 9:15 a.m. Resident #43 said a few nights ago (4/3/26), over the weekend, he asked the nurse (LPN #3) what pills he was taking. He said LPN #3 told him that if he did not want to take his (expletive) pills then he did not have to. According to Resident #43, LPN #3 slammed the pills down on the table and left. He said he felt bad about the interaction with the nurse, so he had to lay down and relax. He said he did not know what to say afterwards and felt very frustrated. He said he was always told that it was his right to ask what medication he received. He said he wanted to find out what the problem was, so he went to the hallway to talk to her. He said since it was night time, he was wearing a shirt and underwear at the time because that was what he slept in. He said he did not feel he should have to get fully dressed again to ask her a question. Resident #43 said LPN #3 yelled at him again because he came out to the hall without pants over his underwear. He said she grabbed him by the arm and pushed him through his room doorway. He said the nurse was very, very upset and he was shocked. He said he could not figure out what he did wrong and she just blew up at him. He said he reported the incident the next morning (4/4/26) to someone in the front office. Resident #43 said he believed someone must have spoken to the nurse (LPN #3) because the next day she was his nurse again but was very nice and explained his pills to him. He said the staff all knew about the incident and he filled out a report (see 4/6/26 grievance form below). He said the way the LPN #3 treated him was abusive, was not professional and lacked nurse character. He said he did not want LPN #3 to be his nurse again. He said he did not understand why she was so mad at him. He said his roommate (Resident #12)was also in the room during the incident. 3. Additional resident interviewResident #12 (Resident #43's roommate) was interviewed on 4/7/26 at 9:20 a.m. Resident #12 said the nurse (LPN (continued on next page)

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	065119	A. Building B. Wing	04/09/2026

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Valley Manor Care Center	1401 S Cascade Ave Montrose, CO 81401

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F 0609 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	#3) was mad at Resident #43 and slammed his pills on the table. He said the pills went everywhere. He said a staff member later looked for the pills under the dresser with a flashlight. He said after LPN #3 slammed the pills on the table, she stayed outside of the room with her cart and he heard her slamming things around. Resident #12 said he was interviewed by staff and he filled out a report (grievance form). 4. Record reviewThe 4/6/26 grievance form for Resident #43 was provided by the NHA on 4/8/26 at 6:35 p.m. The grievance form documented that on 4/3/26, Resident #43 felt the nurse on the overnight shift did not like him asking about his pills and threw his pills on the floor. Resident #43 was told that if he did not want the pills he did not have to take them. The grievance form documented Resident #43 walked outside of his room to talk to someone but the nurse (LPN #3) shoved him back into his room.Review of the State Agency portal revealed the facility reported the incident on 4/9/26 at 10:36 a.m., six days after the incident occurred, five days after Resident #43 reported the incident to the front office employee and three days after the resident filed a grievance form regarding the incident. Cross reference F610: failure to thoroughly investigate an allegation of abuse.5. Staff interviewsCertified nurse aide (CNA) #9 was interviewed on 4/7/26 on 4:48 p.m. CNA #9 said she saw Resident #43 was very upset over the weekend and reported an incident between him and LPN #3 to the staffing coordinator and possibly another nurse. She said the social services director (SSD) was aware of the incident. She said Resident #12 told her the night nurse was very nasty to Resident #43. The SSD was interviewed on 4/7/26 at 4:53 p.m. The SSD said she was called by staff on Saturday (4/4/26) about an incident that happened at night on 4/3/26. She said she was not at the facility at the time but notified the NHA and the director of nursing (DON). -However, the facility failed to report the allegation of abuse until 4/9/26.The SSD said she met with Resident #43 on 4/6/26. She said Resident #43 said he thought some of his medications were discontinued and he asked the nurse (LPN #3) what medication he received. The SSD said he told her that LPN #3 became upset with him, was very rude to him and was kind of aggressive in her tone and meanness. She said he told her that the nurse was pretty mad when he asked about the medication and slammed the medication on the bedside table. She said he thought some of the medication rolled onto the floor. The SSD said Resident #43 told her that LPN #3 told him he could not be out in the hall without his clothes on and led him by his arm back to his room. The SSD said Resident #43 was still distressed about the 4/3/26 incident on Monday 4/6/26 when she interviewed him. The SSD said she interviewed Resident #43's roommate, Resident #12, on 4/6/26. She said Resident #12 saw the incident and reported the LPN #3 was not at all nice to Resident #43. She said both Resident #43 and Resident #12 filled out a grievance form on 4/6/26 with another staff member regarding the 4/3/26 incident. The SSD said allegations, such as the one reported by Resident #43 would usually be reported to the State Agency and investigated. Cross reference F610: failure to thoroughly investigate an allegation of abuse.The SSD said when there were allegations of potential abuse with a staff member, the facility reported the incident and investigated it. She said she was told by the DON that Resident #43 and LPN #3 had worked it all out on Sunday (4/5/26) and there was no malintent. The NHA and the DON were interviewed together on 4/8/26 at 4:58 p.m. The NHA said when a grievance was submitted by a resident, it was first triaged to the appropriate department and the SSD would let her know if something needed to be addressed right away, such as if it was a reportable incident or if it was an immediate nursing concern. The DON said Resident #43 was upset Friday night (4/3/26) because he was not going home on 4/3/26 and was confused about his medication changes. The DON said Resident #43 reported to staff that his nurse (LPN #3) was rude to him on 4/3/26. The DON said she spoke to LPN #3 and was told by the nurse that Resident #43 asked what medications he was getting. The DON said the nurse reported that she told Resident #43 that she would have to check on the computer, which upset him. The DON said LPN #3 should have already known what he was getting so she could tell him. The DON said the following day (4/4/26), Resident #43 was still upset and wanted to have a meeting about the incident. The NHA said she received Resident #43 and Resident #12's grievances on 4/6/26 regarding the 4/3/26 concerns. The NHA said she felt the incident was already (continued on next page)

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	065119	A. Building B. Wing	04/09/2026

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
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F 0609 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	looked at, felt Resident #43 was not at risk and the grievances did not meet reporting criteria. The NHA said at first she thought Resident #43's concerns were possibly a verbal abuse allegation but there was no intent to cause harm and there was not a negative outcome. She said she did not feel Resident #43's concern was physical abuse because there was no harm. The NHA said Resident #43 did not have an injury related to the incident, he did not indicate that he was fearful and there was no physical outcome. The NHA said she felt the grievance was in a grey area and there was nothing that the resident said that indicated possible abuse or that he was emotionally harmed. The NHA said the words Resident #43 used, such as shoved and slammed, in the grievance would need to be clarified but felt they had an understanding of what had happened. The NHA said she did not know if anyone asked Resident #43 if he felt the situation was abuse. She said the resident never expressed that the incident was that serious in level. The NHA and the DON were interviewed together a second time on 4/9/26 at 2:20 p.m. The NHA said she reported Resident #43's allegation of abuse on 4/8/26 (five days after the incident occurred), after it was identified that he felt that was abused by LPN #3. The NHA said she was aware of Resident #43's grievance but she had not had a chance to talk to him yet. The DON said she became aware of Resident #43's medication concern and that LPN #3 was rude after an employee texted her on 4/4/26. She said she thought the issue was resolved over the weekend. She said she had not talked to Resident #43 before he reported the incident to staff. The DON said the determination that the issue was resolved was based on her conversation with LPN #3. The NHA said the incident was not reported to the State Agency on 4/4/26 or 4/6/25 because she did not know Resident #43 felt the incident was abuse. The NHA said it was not a clear allegation of abuse at the time. The NHA said they just had bits and pieces of what happened. The NHA said if they had the full story, then they would have been able to better determine if the incident needed to be reported and investigated earlier.The DON said an allegation of abuse was not on the radar at the time the incident was reported to her on 4/4/26. The staff coordinator was interviewed on 4/9/26 at 4:52 p.m. The staff coordinator said she was working on 4/4/26 when Resident #43 came to her and said he wanted to meet with upper management right away. She said he was tearful and really upset. She said she was told that the night nurse was short with him. The staff coordinator said she told Resident #43 that management might not be able to meet right away on 4/4/26 but they would talk to him at least by Monday (4/6/26).III. Allegation of abuse by LPN #3 towards Resident #39 A. Resident #39 (alleged victim)1. Resident statusResident #39, age greater than 65, was admitted on [DATE]. According to the April 2026 CPO, diagnoses included dysphagia, pharyngoesophageal phase, age related osteoporosis, cognitive communication deficits and anxiety. According to the 4/7/26 MDS assessment, Resident #39 was cognitively intact with a BIMS score of 15 out 15. The MDS assessment indicated Resident #39 used a wheelchair for mobility dependent on staff for most of her activities of daily living (ADL). 2. Resident interview Resident #39 was interviewed on 4/6/26 at 4:02 p.m. Resident #29 said she woke up with LPN #3 putting pills in her mouth and checking her body for patches about a week ago She said she was upset about it and reported her concern and filled out a grievance form. 3. Record reviewReview of the State Agency portal revealed the facility did not report an allegation of abuse by LPN #3 to the State Agency.Review of Resident #39's progress notes did not document Resident #39's concerns about nursing care.A 4/6/26 grievance form was provided by the NHA on 4/8/26 at 6:35 p.m. The grievance form documented Resident #39 stated she was asleep on the night nurse LPN #3 came into her room and shoved pills down her throat. The nurse told the resident that she also had to check to see if she had a patch on after the resident told her the prior staff member took the patches off. According to the grievance form, Resident #39 was concerned because she did not want to choke on pills and did not want to be woken up with pills being shoved in her mouth. The grievance summary section of the grievance form documented Resident #39's medication administration record (MAR) identified the resident had two medications before bed and the lidocaine patches were removed at bedtime. The grievance or finding of conclusion section of the grievance form documented the nurse, LPN #3, was a new traveling nurse and did not know that (continued on next page)

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	065119	A. Building B. Wing	04/09/2026

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Valley Manor Care Center	1401 S Cascade Ave Montrose, CO 81401

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F 0609 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Resident #39 did not take her medications lying down. The nurse was educated on the resident's preference. LPN #3 said she needed to confirm that the resident's patches were off of her. The grievance conclusion documented the grievance was partially confirmed and LPN #3 was educated on the resident's preference.-However, the facility failed to report the allegation of abuse to the State Agency.An interview and observation with Resident #39, conducted by the DON on 4/8/26, was provided by the NHA on 4/9/26 at 3:38 p.m. According to the DON's interview and observation, there was no observed concerns when LPN #3 provided medication to Resident #39 on 4/8/26. The interviewed documented Resident #39 felt she was comfortable with LPN #3 and they had made amends.An interview with Resident #39, dated 4/9/26 and documented by the assistant director of nursing (ADON), was provided by the NHA on 4/9/26 at 3:38 p.m. According to the interview, Resident #39 told the ADON that she and LPN #3 had a truce and she no longer had concerns. 4. Staff interviewsThe SSD was interviewed on 4/8/26 at 4:09 p.m. The SSD said she processed and followed up with all the grievances submitted to her. She said she logged the concern and then asked the resident to clarify the information on the grievance form. She said she made a copy of the grievance and then gave the grievance form to the pertaining/appropriate department manager who would address the concern and action. The SSD said she usually would follow up to determine if the concern was resolved. The SSD said Resident #39 was very mad about the incident and was upset regarding how she was treated by LPN #3. The SSD said she took two whole pills at night and was worried she could have choked. She said the 4/3/26 incident with LPN #3 was not reported to her until 4/6/26. The SSD said the word shoved would have triggered her to report the allegation and investigate it. She said she confirmed with Resident #39 that the resident felt the nurse shoved her pills down her throat and took the grievance to the NHA and the DON. She said they said they would talk to LPN #3 and sort it out. The SSD said she would have reported and investigated when Resident #43 and Resident #39 used triggering word such as shoved during interactions with LPN #3 and the word slammed used by Resident #43. She said that was why she asked the NHA and the DON to review the grievances. The NHA and the DON were interviewed together on 4/8/26 at 4:58 p.m. The DON said LPN #3 was new to Resident #39. The DON said Resident #39 reported that LPN #3 checked her pain patches and shoved pills down her throat while the resident was laying down. The DON said there was no investigation or reporting, other than the grievance form, because Resident #39 said she was okay after LPN #3 later talked to her. The DON said LPN #3 was educated on how Resident #39 preferred to take her medication. The DON said she did not feel the concerns Resident #39 had with LPN #3 were the same as the concerns that Resident #43 had with LPN #3 on 4/3/26. IV. Incident between Resident #76 and the occupational therapist (OT) A. Resident #76 1. Resident statusResident #76, age greater than 65, was admitted on [DATE] and discharged on 12/31/25. According to the December 2025 CPO, diagnoses included a displaced fracture of the greater trochanter of the left femur, subsequent encounter for closed fracture with routine healing and diabetes mellitus. According to the electronic medical record (EMR), the resident had abnormalities of gait and mobility.The 12/5/25 MDS assessment identified Resident #76 was cognitively intact with a BIMS score of 14 out 15. The MDS assessment indicated Resident #76 had impairment to one side of his upper and lower extremities. He was dependent on staff to sit to stand and to transfer from surface to surface. According to the MDS assessment, the resident used a wheelchair for mobility. The MDS assessment indicated Resident #76 did not have physical or verbal behaviors or behavioral symptoms directed towards himself or others. 2. Representative interviewResident #76's representative was interviewed on 4/8/26 at 1:03 p.m. The representative said Resident #76 was admitted to the facility for therapy but felt the therapists were borderline abusive. She said Resident #76's other representative would often attend the therapy sessions with Resident #76. She said one of the therapists yelled at Resident #76 and kicked his foot to move it. She said the therapist said he was not going to work with him anymore. She said the other representative reported the kick from the therapist to Resident #76 to the staff. She said she discharged Resident #76 shortly after the incident because she was unhappy with (continued on next page)

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	065119	A. Building B. Wing	04/09/2026

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
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F 0609 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	the care and wanted him to go somewhere that he would get more therapy.3. Record reviewA 12/22/25 email was reviewed with the SSD on 4/9/26 at approximately 3:30 p.m. The email identified the SSD reported concerns of potential abuse to the NHA. According to the email, Resident #76's representative felt she had observed the OT kick Resident #76 during a therapy session. A 12/22/25 occupational therapy note was provided by the NHA on 4/9/26 at 7:57 a.m. The note documented Resident #76 yelled and told the OT don't push me around like that during the 12/22/25 occupational therapy session. The note documented the OT did not feel safe continuing to practice transfers if Resident #76 was going to be verbally aggressive and not pay attention to verbal cues. According to the note, the OT told the resident he did not feel comfortable continuing the session and he assisted Resident #76 back to his room in his wheelchair. -However, review of the State Agency portal did not reveal the facility reported the allegation of abuse. 4. Staff interviewsThe director of rehabilitation, the DON and the nurse manager were interviewed together on 4/9/26 at 1:06 p.m. The director of rehabilitation said Resident #76 had physical therapy three times a week and occupational therapy twice a week. The DON said Resident #76 reported that he was kicked by a therapist. The DON said they reviewed the situation and spoke with the OT. -However, the facility failed to report the allegation of physical abuse to the State Agency. The director of rehabilitation said Resident #76's left foot had to be lifted related to his history of a stroke. She said when the therapists would move his foot with their foot, it could have been misconstrued as a kick. The director of rehabilitation said the way Resident #76 would want to move was not safe and he did not have good safety judgement. She said sometimes he did not understand what the therapists were trying to do. The nurse manager and the director of rehabilitation said they spoke to the OT about the kicking concern. The nurse manager said she held a care conference about it. The director of rehabilitation said she did not think she was in the facility at the time of the care conference.The NHA was interviewed on 4/9/26 at 2:14 p.m. The NHA said she was aware of the kicking incident reported by Resident #76's representative on 12/22/26. The NHA said it was quickly determined that the OT was lifting up the resident's foot to move it. The SSD was interviewed on 4/9/26 at 3:21 p.m. The SSD said Resident #76's representative mentioned in a care conference that she observed the OT kick Resident #76 in the foot. The SSD said she asked either the director of rehabilitation or the OT to speak to the representative. The SSD said as far as she knew, the concern was not resolved. The NHA was interviewed a second time on 4/9/26 at 5:01 p.m. The NHA said the incident between Resident #76 and the OT was not reported or investigated for alleged abuse. She said she felt the representative's concern regarding the kicking of his foot was handled and resolved. She said Resident #76 was later discharged . The NHA said she was not aware of the 12/22/25 OT note that documented that Resident #76 told the OT not to push him around.

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	065119	A. Building B. Wing	04/09/2026

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F 0610 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Respond appropriately to all alleged violations. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on record review and interviews, the facility failed to thoroughly and timely investigate an allegation of abuse involving two (#43 and #76) of five residents reviewed for abuse out of 36 sample residents.Specifically, the facility failed to:-Thoroughly investigate an allegation of abuse by licensed practical nurse (LPN) #3 towards Resident #43; and,-Thoroughly investigate an allegation of abuse by the occupational therapist (OT) towards Resident #76. Findings include:I. Facility policy and procedureThe Abuse, Neglect, Exploitation or Misappropriation - Reporting and Investigating policy, initiated 3/2/26, was provided by the nursing home administrator (NHA) on 4/9/26 at 5:35 p.m. It read in pertinent part, This policy establishes (the facility's) commitment to protecting the safety, dignity, and well-being of at-risk adults by defining requirements for identifying, reporting, investigating, and responding to suspected mistreatment in accordance with Colorado regulations. Any (facility) employee or volunteer who has reason to believe that an at-risk adult has been mistreated or is at imminent risk of mistreatment will immediately report this concern to their supervisor, Administrator/Executive Director, or designee. Upon receipt of a report of suspected mistreatment of an at-risk adult, the facility or program will initiate an internal investigation to determine whether the alleged incident occurred and to ensure appropriate protective and corrective actions are taken. The investigation will be thorough, impartial, and timely, and will be coordinated by the appropriate designated operational and clinical personnel in collaboration with Quality and Compliance as needed.II. Allegation of physical and verbal abuse by LPN #3 towards Resident #43 A. Facility investigation A request was made for the investigation regarding the allegation of physical abuse verbal abuse on 4/8/26 at approximately 5:00 p.m. The NHA said the facility did not have a full investigation of the allegation incident (see interviews below). B. Resident #43 (alleged victim)1. Resident statusResident #43, age greater than 65, was admitted on [DATE]. According to the April 2026 computerized physician orders (CPO), diagnoses included adult failure to thrive, chronic atrial fibrillation unspecified and kidney disease stage three. According to the 4/7/26 minimum data set (MDS) assessment Resident #43 had moderate cognitive impairment with a brief interview for mental status (BIMS) score of 10 out 15. The MDS assessment indicated Resident #43 used a walker for mobility and required partial to moderate assistance for dressing. According to the MDS assessment, Resident #43 did not have physical or behavioral systems directed to others. 2. Resident interview Resident #43 was interviewed on 4/7/26 at 9:15 a.m. Resident #43 said a few nights ago (4/3/26), over the weekend, he asked the nurse (LPN #3) what pills he was taking. He said LPN #3 told him that if he did not want to take his (expletive) pills then he did not have to. According to Resident #43, LPN #3 slammed the pills down on the table and left. He said he felt bad about the interaction with the nurse, so he had to lay down and relax. He said he did not know what to say afterwards and felt very frustrated. He said he was always told that it was his right to ask what medication he received. He said he wanted to find out what the problem was, so he went to the hallway to talk to her. He said since it was night time, he was wearing a shirt and underwear at the time because that was what he slept in. He said he did not feel he should have to get fully dressed again to ask her a question. Resident #43 said LPN #3 yelled at him again because he came out to the hall without pants over his underwear. He said she grabbed him by the arm and pushed him through his room doorway. He said the nurse was very, very upset and he was shocked. He said he could not figure out what he did wrong and she just blew up at him. He said he reported the incident the next morning (4/4/26) to someone in the front office. Resident #43 said he believed someone must have spoken to the nurse (LPN #3) because the next day she was his nurse again but was very nice and explained his pills to him. He said the staff all knew about the incident and he filled out a report (see 4/6/26 grievance form below). He said the way the LPN #3 treated him was abusive, was not professional and lacked nurse character. He said he did not want LPN #3 to be his nurse again. He said he did not understand (continued on next page)

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	065119	A. Building B. Wing	04/09/2026

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F 0610 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	why she was so mad at him. He said his roommate (Resident #12)was also in the room during the incident. 3. Additional resident interviewResident #12 (Resident #43's roommate) was interviewed on 4/7/26 at 9:20 a.m. Resident #12 said the nurse (LPN #3) was mad at Resident #43 and slammed his pills on the table. He said the pills went everywhere. He said a staff member later looked for the pills under the dresser with a flashlight. He said after LPN #3 slammed the pills on the table, she stayed outside of the room with her cart and he heard her slamming things around. Resident #12 said he was interviewed by staff and he filled out a report (grievance form).4. Record reviewThe 4/6/26 grievance form for Resident #43 was provided by the NHA on 4/8/26 at 6:35 p.m. The grievance form documented that on 4/3/26, Resident #43 felt the nurse on the overnight shift did not like him asking about his pills and threw his pills on the floor. Resident #43 was told that if he did not want the pills he did not have to take them. The grievance form documented Resident #43 walked outside of his room to talk to someone but the nurse (LPN #3) shoved him back into his room.The summary of the grievance, documented by the social service director (SSD) on 4/6/26, read Resident #43 was under the impression that his medication was discontinued. He asked the nurse what the pills were and was told they were the pills he always took. According to the summary of the grievance, the nurse slammed the pills down on the bedside table. The pills spilled and the nurse told the resident to take them or do not take them. The summary documented Resident #43 later walked to the nurse to talk to her and she told him he could not be without pants on and took him by the arm and walked him back to his room and told him to go back to bed. The grievance form summary of steps taken to investigate the grievance and the findings/conclusion, dated 4/7/26, identified the director of nursing (DON) documented she spoke with the nurse (LPN #3) on 4/4/26 about the medication concerns prior to receiving the grievance form. According to the grievance findings/conclusion, LPN #3 had already spoken to Resident #43 and went over the medication changes and explained the current medications. The findings/conclusion documented there was no confirmation of spilled medication. The grievance form documented the grievance was partially confirmed due to questions of medications and the nurse was re-educated regarding knowing what a resident's medications were before giving them to a resident. According to the grievance form, Resident #43 was discharged on 4/7/26 and he did not work with LPN #3 after the 4/3/26 overnight shift. The 4/6/26 grievance form for Resident #12 (roommate of Resident #43) was provided by the NHA on 4/9/26 at 9:36 a.m. The grievance form documented Resident #12 witnessed LPN #3 being very rude to Resident #43 on 4/3/26. He said the nurse made him very angry and she was not a good nurse to Resident #43. According to the grievance, Resident #12 said it was a very upsetting situation.The summary of the grievance, documented by the SSD on 4/6/26, identified the SSD confirmed Resident #12's grievance statements. The grievance form summary of steps taken to investigate the grievance and the findings/conclusion, dated 4/6/26, documented Resident #12 was unable to give details about what occurred and said he agreed with what his roommate said. According to the grievance, Resident #12 was concerned about the situation for his roommate but not concerned about himself or interacting with LPN #3.An undated statement, signed by the DON, was provided by the NHA on 4/8/26 at 6:35 p.m. The statement documented the DON asked LPN #3 on 4/4/26 to describe her interactions with Resident #43 on 4/3/26. The statement documented Resident #43 was frustrated and upset with LPN #3 because she could not identify all the medication she was giving him. The statement documented LPN #3 told the DON that later on the night of 4/3/26, Resident #43 came out of his room in his underwear and she mentioned that he should probably not be in the hallway with just his underwear on and she walked him back to his room. According to the statement, the DON commented that LPN #3 should have known what medications were being given to residents and should provide an explanation/information to the residents going forward. The statement indicated LPN #3 brought her computer down to Resident #43 on 4/4/26 and explained all his medication to him, and she felt their interaction with each other was good and Resident #43 was joking around with her. LPN #3's statement regarding the incident on 4/3/26, dated 4/7/26, was provided by the NHA on 4/8/26 on 6:35 p.m The statement documented (continued on next page)

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	065119	A. Building B. Wing	04/09/2026

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F 0610 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	that LPN #3 introduced herself to Resident #43 and asked him his name. She provided him his medication in a medication cup between 7:00 p.m. and 8:00 p.m. while he sat on the side of the bed with his bedside table in front of him. The statement documented the resident asked what medication he was receiving and she named off what she could remember and told him that she could look up the rest for him. She said Resident #43 became frustrated and angry and said some not nice things. According to the statement, LPN #3 told Resident #43 that he did not have to take the medication but he took the medication and she left his room. The statement documented LPN #3 said Resident #43 walked out of his room in his underwear and told her he wanted to talk to her. The statement documented LPN #3 told him he should not be out of his room in his underwear and they could walk and talk down to his room. The statement documented that Resident #43 said it was his right to know his medication and he wanted a meeting with someone on the following day (4/4/26). She said she apologized for not knowing how things were done at the facility. The statement documented that she reviewed his medication with him on the night of 4/4/26, he took his medication and there were no other concerns. The statement documented she only had verbal interactions with Resident #43 and did not put her hands on him. A 4/9/26 statement, signed by the NHA and the DON, was provided by the NHA on 4/9/26 at 5:35 p.m. The 4/9/26 statement documented the NHA and the DON contacted Resident #43's representative. According to the statement, Resident #43 was sleeping at the time of the call and the representative was not aware of any concerns or problems he had at the facility. The statement documented Resident #43 was asked to call her back when he could. Review of Resident #43's progress notes did not document the 4/3/26 incident or allegation between Resident #43 and LPN #3.5. Staff interviewsCertified nurse aide (CNA) #9 was interviewed on 4/7/26 at 4:48 p.m. CNA #9 said she saw Resident #43 was very upset over the weekend (4/3/26) and reported an incident between himself and LPN #3 to the staffing coordinator and possibly another nurse. She said the SSD was aware of the incident. She said Resident #12 told her the night nurse was very nasty to Resident #43. The SSD was interviewed on 4/7/26 at 4:53 p.m. The SSD said she was called by staff on Saturday (4/4/26) about an incident that happened at night on 4/3/26. She said she was not at the facility at the time but notified the NHA and the DON. The SSD said she met with Resident #43 on 4/6/26. She said Resident #43 said he thought some of his medications were discontinued and he asked the nurse (LPN #3) what medication he received. The SSD said he told her that LPN #3 became upset with him, was very rude to him and was kind of aggressive in her tone and meanness. She said he told her that the nurse was pretty mad when he asked about the medication and slammed the medication on the bedside table. She said he thought some of the medication rolled onto the floor. The SSD said Resident #43 told her that LPN #3 told him he could not be out in the hall without his clothes on and led him by his arm back to his room. The SSD said Resident #43 was still distressed about the 4/3/26 incident on Monday 4/6/26 when she interviewed him. The SSD said she interviewed Resident #43's roommate, Resident #12, on 4/6/26. She said Resident #12 saw the incident and reported the LPN #3 was not at all nice to Resident #43. She said both Resident #43 and Resident #12 filled out a grievance form on 4/6/26 with another staff member regarding the 4/3/26 incident.The SSD said allegations, such as the one reported by Resident #43 would usually be reported to the State Agency and investigated. She said she was often the lead in abuse allegations but she was not involved in the 4/3/26 investigation other than interviewing Resident #43 and Resident #12 related to their grievances. She said she was the grievance coordinator for the facility. The SSD said the incident between LPN #3 and Resident #43was not discussed with the interdisciplinary team (IDT). She said she was told by the DON that Resident #43 and LPN #3 had worked it all out on Sunday (4/5/26) and there was no malintent. Cross reference F609: failure to report an allegation of abuse to the State Agency.The SSD said when there were allegations of potential abuse with a staff member, the facility would report the incident and investigate it. She said the investigation would include interviewing the resident and other residents that may have witnessed the incident or had similar experiences with the same staff member. She said the staff members involved in the allegation and (continued on next page)

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	065119	A. Building B. Wing	04/09/2026

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F 0610 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	other staff members would be interviewed. She said the facility then would make a determination on if the allegation was substantiated. The SSD said she was not sure why the 4/3/26 was handled differently. The NHA and the DON were interviewed together on 4/8/26 at 4:58 p.m. The NHA said when a grievance was submitted by a resident it was first triaged to the appropriate department and the SSD would let her know if something needed to be addressed right away such as if it was a reportable incident or if it was an immediate nursing concern. The DON said Resident #43 was upset Friday night (4/3/26) because he was not going home on 4/3/26 and was confused about his medication changes. The DON said Resident #43 reported to staff that his nurse (LPN #3) on 4/3/26 was rude to him. The DON said she spoke to LPN #3 and was told by the nurse that Resident #43 asked what medications he was getting. The DON said the nurse reported that she told Resident #43 that she would have to check on the computer, which upset him. The DON said LPN #3 should have already known what the resident was getting so she could tell him. The DON said the following day, Resident #43 was still upset and wanted to have a meeting about the incident on 4/4/26. The DON said LPN #3 reviewed all his medications with him and he chose which ones he wanted to take. She said LPN #3 told her that she did leave the medications in his room but did not say anything about slamming them down. The DON said LPN #3 told her that she did not grab his arm and purposely take him to his room. She said LPN #3 reported that she might have accidentally touched the resident's arm but she did not remember. The NHA and the DON said they felt like a mini-investigation was already done when the DON had a conversation with LPN #3 over the weekend and was fact finding before the grievance was written on 4/6/26. The DON said she did a verbal education over the phone with LPN #3 regarding medications. The DON said LPN #3 provided a written statement on what happened on 4/3/26 and LPN #3 told Resident #43 that he could have another nurse if he wanted one but the resident said he was okay. The DON said if she knew Resident #43 was really upset over the weekend about the incident, she would have come in to talk to him. The NHA said she received Resident #43 and Resident #12's grievances on 4/6/26 regarding the 4/3/26 concerns. The NHA said she felt the incident was already looked at, felt that Resident #43 was not at risk and the grievances did not meet reporting criteria. The NHA said at first she thought Resident #43's concerns were possibly a verbal abuse allegation but there was no intent to cause harm and there was not a negative outcome. She said she did not feel the resident's concern was physical abuse because there was no harm. The NHA said Resident #43 did not have an injury related to the incident, he did not indicate that he was fearful and there was no physical outcome. The NHA said she felt the grievance was in a grey area and there was nothing that the resident said that indicated possible abuse or that he was emotionally harmed. The NHA said the words he used, such as shoved and slammed in the grievance would need to be clarified but felt they had an understanding on what happened. The NHA said she did not know if anyone asked Resident #43 if he felt the situation was abuse. She said he never expressed the incident was that serious in level. The NHA said the nurse probably could have used a better approach. The DON said the SSD interviewed Resident #12 on 4/6/26 about the incident. She said Resident #12 reported that he agreed with what Resident #43 said. The DON said Resident #12 was a poor historian and not able to give details at a later date on specifics. The DON said no other residents were interviewed about LPN #3 or about abuse other than Resident #39. The DON said Resident #39 was interviewed because she submitted a grievance form (see below).The NHA and the DON were interviewed together a second time on 4/9/26 at 2:20 p.m. The NHA said she reported Resident #43's the allegation of abuse on 4/8/26 after it was identified that he felt that was abused by LPN #3. She said the facility started a full investigation. The NHA said Resident #12 was interviewed. She said Resident #43 discharged on 4/7/26 and she tried to call him but he was not available. She said she spoke to his representative and she was not aware of any incidents. The NHA said she did not know if the incident was reported to the representative when it was reported to the facility on 4/4/26. The DON said she was just aware of Resident #43's medication concern and that the nurse was rude after an employee texted her on 4/4/26. She said she thought the issue was (continued on next page)

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	065119	A. Building B. Wing	04/09/2026

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Valley Manor Care Center	1401 S Cascade Ave Montrose, CO 81401

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F 0610 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	resolved over the weekend. She said she did not talk to Resident #43 after he reported the incident to staff. The DON said the determination that the issue was resolved was based on her conversation with LPN #3. The NHA said she did not know if the SSD asked Resident #43 if he felt he was abused. The NHA said she was aware of Resident #43's grievance but she had not had a chance to talk to him yet. The NHA said the facility had an abuse investigation packet they used that included abuse questions. She said the packet was used when the residents reported abuse concerns. She said if someone had asked him directly if he felt he was abused then that might have prompted an abuse investigation and she would have reported earlier to the State Agency. The NHA said it was not a clear allegation of abuse at the time of the incident. The NHA said they just had bits and pieces of what happened. She said they were now finding out a lot of staff had some information pertaining to the incident. The NHA said if they had the full story, then they would have been able to better determine if the incident needed to be reported and investigated earlier.The DON said an allegation of abuse was not on the radar at the time it was reported to her on 4/4/26. She said she knew Resident #43 was upset about the medications and that he felt the nurse was rude to him. The DON said it would have required more interviews with Resident #43 to understand what he meant by rude. The DON said rudeness was not always abuse. The DON said someone should have come in and gotten to the bottom of the incident. The staff coordinator was interviewed on 4/9/26 at 4:52 p.m. The staff coordinator said she was working on 4/4/26 when Resident #43 came to her and said he wanted to meet with upper management right away. She said he was tearful and really upset. She said he told her that the night nurse was short with him. The staff coordinator said she told Resident #43 that management might not be able to meet right away on 4/4/26 but they would talk to him at least by Monday (4/6/26).III. Allegation of physical abuse by the OT towards Resident #76A. Facility investigationA request for the facility's investigation regarding the allegation of physical abuse by the OT towards Resident #76 was requested on 4/8/26 at approximately 5:00 p.m. The NHA said they did not have a documented investigation of the incident(see record review below).A. Resident #76 1. Resident statusResident #76, age greater than 65, was admitted on [DATE] and discharged on 12/31/25. According to the December 2025 CPO, diagnoses included a displaced fracture of the greater trochanter of the left femur, subsequent encounter for closed fracture with routine healing and diabetes mellitus. According to the electronic medical record (EMR), the resident had abnormalities of gait and mobility.The 12/5/25 MDS assessment identified Resident #76 was cognitively intact with a BIMS score of 14 out 15. The MDS assessment indicated Resident #76 had impairment to one side of his upper and lower extremities. He was dependent on staff to sit to stand and to transfer from surface to surface. According to the MDS assessment, the resident used a wheelchair for mobility. The MDS assessment indicated Resident #76 did not have physical or verbal behaviors or behavioral symptoms directed towards himself or others. 2. Resident #76's representative interviewResident #76's representative was interviewed on 4/8/26 at 1:03 p.m. The representative said Resident #76 was admitted to the facility for therapy but felt the therapists were borderline abusive. She said Resident #76's other representative would often attend the therapy sessions with Resident #76. She said one of the therapists yelled at Resident #76 and kicked his foot to move it. She said the therapist said he was not going to work with him anymore. She said the other representative reported the kick from the therapist to Resident #76 to the staff. She said she discharged Resident #76 shortly after the incident because she was unhappy with the care and wanted him to go somewhere that he would get more therapy.3. Record reviewA 12/22/25 email was reviewed with the SSD on 4/9/26 at approximately 3:30 p.m. The email identified the SSD reported concerns of potential abuse to the NHA. According to the email, Resident #76's representative felt she had observed the OT kick Resident #76 during a therapy session. A 12/22/25 occupational therapy note was provided by the NHA on 4/9/26 at 7:57 a.m. The note documented Resident #76 yelled and told the OT don't push me around like that during the 12/22/25 occupational therapy session. The note documented the OT did not feel safe continuing to practice transfers if Resident #76 was going to be verbally aggressive and not pay (continued on next page)

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	065119	A. Building B. Wing	04/09/2026

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F 0610 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	attention to verbal cues. According to the note, the OT told the resident he did not feel comfortable continuing the session and he assisted Resident #76 back to his room in his wheelchair. -However, the facility failed to investigate the allegation of physical abuse. 4. Staff interviewThe director of rehabilitation, the DON and the nurse manager were interviewed together on 4/9/26 at 1:06 p.m. The director of rehabilitation said Resident #76 had physical therapy three times a week and occupational therapy twice a week. The director of rehabilitation said Resident #76 had behaviors during the therapy sessions. She said Resident #76 had difficulty processing information and would be impulsive or argumentative at times. The nurse manager said Resident #76 reported to his representative that he was not going to therapy, so the representative started observing sessions to show he was attending. The DON said Resident #76 reported that he was kicked by a therapist. The DON said they reviewed the situation and spoke with the OT. The director of rehabilitation said Resident #76's left foot had to be lifted related to his history of a stroke. She said when the therapists would move his foot with their foot, it could have been misconstrued as a kick. The director of rehabilitation said the way Resident #76 would want to move was not safe and he did not have good safety judgement. She said sometimes he did not understand what the therapists were trying to do. The nurse manager and the director of rehabilitation said they spoke to the OT about the kicking concern. The nurse manager said she held a care conference about it. The director of rehabilitation said she did not think she was in the facility at the time of the care conference.The NHA was interviewed on 4/9/26 at 2:14 p.m. The NHA said she was aware of the kicking incident reported by Resident #76's representative on 12/22/25. The NHA said it was quickly determined that the OT was lifting up the resident's foot to move it. She said she was not sure when they talked to Resident #76's representative but there was a 12/22/25 email.The SSD was interviewed on 4/9/26 at 3:21 p.m. She said Resident #76's representative mentioned in a care conference that she observed the occupational therapist kick Resident #76 in the foot. The SSD said she asked the OT what happened during the therapy session and he explained to the SSD that he was sliding Resident #76's foot. The SSD said she spoke to Resident #76's representative and told her about the foot sliding technique. She said the representative was more upset about the incident then Resident #76 was. The SSD said the representative said it was possible that it looked rougher than it was, but she would advocate for Resident #76 and wanted to contact the frequent facility visitor. The SSD said the representative felt that the OT should have explained to Resident #76 what he wanted the resident to do, then it would not have been as physical. The SSD said she did not see the 12/22/25 care conference documented in his progress notes. She said the 12/22/25 email that she sent the NHA was the only documentation to follow up on the concerns that she was aware of. The SSD said she asked either the director of rehabilitation or the OT to speak to the representative. The SSD said as far as she knew, the concern was not resolved. The NHA was interviewed a second time on 4/9/26 at 5:01 p.m. The NHA said the incident between Resident #76 and the OT was not investigated for alleged abuse. She said she felt the representative's concern regarding the kicking of his foot was handled and resolved. She said Resident #76 was later discharged . The NHA said she was not aware of the 12/22/25 OT note that documented that Resident #76 told the OT not to push him around.

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	065119	A. Building B. Wing	04/09/2026

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Valley Manor Care Center	1401 S Cascade Ave Montrose, CO 81401

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F 0688 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide appropriate care for a resident to maintain and/or improve range of motion (ROM), limited ROM and/or mobility, unless a decline is for a medical reason. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observations, record review, and interviews, the facility failed to ensure residents with limited range of motion received appropriate treatment and services to increase range of motion and/or to prevent further decrease in range of motion for one (#3) of three residents out of 36 sample residents. Specifically, the facility failed to: -Ensure Resident #3's brace was consistently implemented; and, -Ensure range of motion exercises were consistently completed for Resident #3's contracture. Findings include:I. Facility policy and procedureThe Rehabilitative Services policy and procedure, revised 7/10/19, was provided by the assistant director of nursing (ADON) on 4/9/26 at 5:55 p.m. It read in pertinent part, The facility must ensure that a resident who enters the facility without limited range of motion does not experience reduction in range of motion unless the resident's clinical condition demonstrates that a reduction in range of motion is unavoidable; and a resident with limited range of motion receives appropriate treatment and services to increase range of motion and/or to prevent further decrease in range of motion. A resident with limited mobility receives appropriate services, equipment, and assistance to maintain or improve mobility with the maximum practicable independence unless a reduction in mobility is demonstrably unavoidable. Range of motion (ROM means the full movement potential of a joint. Active ROM means the performance of an exercise to move a joint without any assistance or effort of another person to the muscles surrounding the joint. Active Assisted ROM means the use of the muscles surrounding the joint to perform the exercise but requires some help from the therapist or equipment (such as a strap). Based upon the assessment, the care plan interventions must include the provision of necessaryequipment and/or services necessary, adapting the environment to meet the needs of the resident, the use of equipment for bed mobility, walkers, canes, splints, braces or other rehabilitative equipment as prescribed by the attending practitioner and/or as allowed by state law, and PT/OT (physical therapy/occupational therapy). Examples of interventions may include treatments such as active, passive, and/or active-assisted ROM, muscle strengthening and stretching exercises, land and/or water based activities, and/or specific physical and/or occupational therapies.II. Resident #3A. Resident statusResident #3, age greater than 65, was admitted on [DATE]. According to the April 2026 computerized physician orders (CPO), diagnoses included cerebral infarction affecting the left non-dominant side, hemiplegia and hemiparesis (weakness and loss of function of one side of the body), unspecified convulsions, chronic pain, muscle weakness, depression, dysphagia, carpal tunnel syndrome, paresthesia of the skin (pins and needles) and hypertension.The 3/18/26 minimum data set (MDS) assessment revealed Resident #3 was cognitively intact with a brief interview for mental status (BIMS) score of 14 out of 15. Resident #3 was dependent on staff for putting on footwear, toileting, oral hygiene and bathing. Resident #3 required substantial assistance with personal hygiene, upper and lower body dressing. Resident #3 had functional limitations to range of motion to the left upper and lower extremities.B. Resident interviewResident #3 was interviewed on 4/09/26 at 9:11 a.m. Resident #3 said his left arm did not listen to him any more and he had carpal tunnel in his right hand. Resident #3 said he used to have a blue brace for his left arm and a smaller white brace for his right hand. Resident #3 said he wore the blue brace a couple of times, but then it went missing a long time ago. He said he did not know where it was. Resident #3 said if the braces were available he would want to wear it at least some of the day to keep his hand in a comfortable position. Resident #3 said he did not remember any staff completing ROM exercises with him other than when he was doingPT with the facility over a year ago.C. ObservationsOn 4/6/26 at 3:07 p.m. Resident #3 did not have a brace on either hand. Resident #3's left arm was flaccid and his hand rested in a closed position, making a fist. Resident #3 was able to reposition his left arm using his right hand. Resident #3 was able to open the fingers of his left hand with his right hand. On 4/8/26 at 10:00 a.m. Resident (continued on next page)

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	065119	A. Building B. Wing	04/09/2026

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Valley Manor Care Center	1401 S Cascade Ave Montrose, CO 81401

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F 0688 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	#3 was in the group interview without a brace for either hand.On 4/9/26 at 9:54 a.m. Resident #3 did not have a brace on either hand. Certified nurse aide (CNA) #1 and CNA #2 looked in Resident #3's room including all of Resident #3's personal storage areas, but were unable to locate braces for Resident #3. C. Record reviewResident #3's care plan, revised 4/2/26, revealed a care plan focus for the restorative nursing program. The care plan directed staff to assist Resident #20 with ROM twice a day to move through his tolerated range with supporting joints through five repetitions each on the following motions: shoulder flexion, abduction/adducation, interntal/external rotation, elbow flexion and extension, forearm supination and pronation, wrist flexion, extension and rotation, finger flexion and extension. Additional interventions included providing a splint to Resident #20's left hand and forearm after doing passive ROM in the evening and before putting on in the morning.Review of Resident #3's CNA restorative program tasks revealed the following in pertinent part,CNA task for passive range of motion (PROM) to Resident #3's left upper extremity; assist to move through the tolerated range, support the joints about and below the shoulder with abduction and adduction, as well as internal and external rotation. Assist to move through the tolerated range, support the joints with flexion and extension of the elbow; and with supination and pronation of the forearm. Complete five repetitions to each area, twice a day.CNA task for splinting program: apply splint to left hand after completing PROM to wrist, hand and fingers. Apply the brace at bedtime and remove it in the morning.-However, observations revealed the resident did not have a splint in place (see observations above).Review of the CNA task for PROM of Resident #3's left upper extremity documented Resident #3 received PROM 12 out of the last 30 days.Review of the CNA task for splinting of Resident #3's left hand documented Resident #3 had a brace applied twice out of the last 30 days. III. Staff interviewsCNA #1 was interviewed on 4/9/26 at 9:43 a.m. CNA #1 said she knew Resident #3 previously had a brace for his left arm because she used to work the evening shift approximately a year ago. She said she would assist with ROM and placement of the brace when assisting Resident #3 before bed. CNA #1 said she now worked the morning shift, and she had not seen the brace recently. She said she assumed the brace was still in Resident #3's room and was still being applied every evening. CNA #1 said she completed ROM with Resident #3 by asking Resident #3 to move the extremities he was able to control while assisting Resident #3 with getting dressed followed by CNA #1 assisting Resident #3 to open his left hand. CNA #1 said the way she assisted with ROM was more active ROM than passive ROM. CNA #1 said she was not sure if the task was to provide Resident #3 with active ROM or passive ROM. CNA #1 and CNA #2 were interviewed together on 4/9/26 at 10:04 a.m. CNA #1 said it was possible that Resident #3's roommate had taken Resident #3's brace. CNA #2 said they did not look through any of Resident #3's roommate's storage when looking through his room to prevent Resident #3's roommate from getting upset. CNA #2 said Resident #3's roommate had a history of rummaging through and taking other people's objects, then becoming upset when staff try to give the items back to Resident #3. The director of rehabilitation and the director of nursing (DON) were interviewed together on 4/9/26 at 1:06 p.m. The director of rehabilitation said she had not seen Resident #3 for physical therapy (PT) or occupational therapy (OT) in over a year.The DON said she did not remember Resident #3 participating in PT or OT for a couple of years. The director of rehabilitation said she did not have any documentation from the last time Resident #3 received physical therapy because the charting system changed since the last time Resident #3 received PT or OT. The director of rehabilitation said a splint as described in the restorative nursing task was not accurate and it was more likely that it was recommended for Resident #3 to have a brace to prevent contracture. The DON said typically a brace was considered a treatment and Resident #3 should have also had an order for the brace. The director of rehabilitation said the nursing staff were responsible for implementing the tasks designated in a resident's restorative care plan, and she would provide oversight and education. The director of rehabilitation said she could not say if the restorative interventions for Resident #3 were still appropriate without re-assessing Resident #3.

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	065119	A. Building B. Wing	04/09/2026

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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 record review and interviews, the facility failed to ensure an environment free from risk of accidents and hazards for one (#44) of four residents reviewed for accident hazards out of 36 sample residents. Specifically, the facility failed to protect Resident #44 from possible ingestion of medications left unattended on the medication cart. Findings include:Record review and interviews confirmed the facility corrected the deficient practice prior to the onsite investigation from 4/6/26 to 4/9/26, resulting in the deficiency being cited as past noncompliance with a correction date of 3/31/26. I. Facility plan of correctionThe corrective action plan was implemented immediately by the facility in response to Resident #44 alleged ingestion of medications. The facility implemented medication cart audits, education and monitoring. The contract nurse was terminated during the investigation. The four medication carts in the facility were audited on 3/16/26 for any discontinued medications and items left on top of the cart. The medication carts were audited again for any discontinued medication or items left on top of the cart at random times on 3/17/26, 3/18/26, 3/20/26, 3/21/26, 3/24/26 and 3/3/26. The current memory care environment safety audit had been increased from weekly to daily. To include all private and public rooms to be inspected and free from any unsafe items. The audit was completed on 3/4/26, daily from 3/9/26 to 3/25/26, 3/28/26 and 3/31/26. Nurse education was completed on 3/18/26 by the DON on the seven rights of safe medication administration. How to store medication safely behind lock and key, disposition of discontinued medications and the process when medication cart was left unattended. Included in the email were the medication cart audits completed at random times and dates which revealed how medications were secured and stored.The memory care staff were reeducated on the on-going supervision or additional help when other staff provided cares to residents. The facility would keep resident safe from further ingestion of medications left on the medication cart.The facility would be in compliance by the end of March 2026.II. Facility policy and procedureThe Medication Error Identification, Reporting and Management policy, dated 8/19/25, was provided by the director of nursing (DON) on 4/6/26 at 6:49 p.m. The policy read in pertinent part, The policy established the requirements for the timely identification, reporting, investigation, and management of actual and potential medication errors in the facilities healthcare programs which reflects the commitment to safeguarding residents or participants safety, high-quality care, regulatory compliance and fostering a culture of accountability, learning, and continuous improvement. The facility will ensure all actual and potential medication errors, including near misses, were promptly reported, thoroughly investigated, and addressed in accordance with the policy. Staff will take immediate action to protect the health and safety of residents or participants,implement provider-directed interventions, and document events in compliance with the policy. Medication errors include:- Wrong Patient. Administering a medication to the wrong resident or participation. -Wrong Medication. Administering a medication not ordered for that resident/participant.- Wrong Dose. Administering too much (overdose) or too little(underdose) of the ordered medication (including duplicate administration).II. Resident #44A. Resident statusResident #44, age [AGE], was readmitted on [DATE]. According to the April 2026 computerized physician orders (CPO), diagnosis included chronic obstructive pulmonary disease (COPD), dementia and depression. The 2/9/26 minimum data set (MDS) assessment revealed the resident was severely cognitively impaired with a brief interview for mental status (BIMS) score of one out of 15. She required maximum assistance with activities of daily living (ADL). B. Facility investigationThe 3/13/26 facility investigation was provided by the director of nursing (DON) on 4/9/26 at 9:30 a.m. The investigation revealed Resident #44 allegedly consumed liquid Citalopram (antidepressant) left on the medication cart, which was unattended for 10 to 15 minutes. The investigation documented the resident was unable to describe where and how she obtained the medication. The investigation documented the bottle potentially had 150 milliliters (ml) of (continued on next page)

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	065119	A. Building B. Wing	04/09/2026

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F 0689 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	medication in it, which the resident may have consumed. The medication was prescribed to another resident. The medication had been discontinued, but not removed from the cart immediately for destruction. The investigation documented the facility attempted to interview RN #2, who was an agency staff member, however the nurse refused to write a statement and gave vague responses when asked questions. The investigation documented due to the lack of participation from the agency nurse, it was unclear how the medication came to be on top of the cart. RN #2 was trained on the facility's policy and procedure of safe medication administration and storage. The investigation documented the attending provider sent orders to monitor the residents pulse and temperature every thirty minutes until 10:00 p.m. that night. Per the facility's policy, obtaining resident's full vital signs were obtained every four hours and level of cognition was monitored. No harm came to the resident, and the resident did not have any reaction to the potential ingestion. Two additional head to toe assessments were completed on 3/17/26 and 3/17/26 and revealed no changes to residents' level of consciousness from baseline. The investigation documented the consulting pharmacist was interviewed by the facility and stated there could be an interaction with the resident's current medication duloxetine (antidepressant) as it was a duplicate therapy order and could carry a small risk of a serotonin effect. The pharmacist also stated the medication citalopram overdose often had mild to moderate symptoms, particularly with ingestion under 600 milligrams.The investigation's conclusion was RN #2 attempted to audit the medication cart. She started the process of medication destruction and was pulled away from the cart without returning the medication inside the cart before leaving the unit. The facility determined RN #2 most likely abandoned the medication on top of the cart and the resident grabbed the medication off the top of the cart when the nurse was not present.C. Record reviewA progress note, dated 3/13/26 at 11:53 a.m., documented the nurse was alerted of an incident in the memory care unit at 10:30 a.m. Resident #44 was found in her wheelchair in the common area of the unit. The note documented the resident had consumed liquid medication. The note documented the resident was alert at baseline with no distress and with no level of conscious change. The resident denied pain and self-ambulated in her wheelchair. She was not able to describe where and how she obtained the medication. The note documented the resident had consumed liquid citalopram that had been left on the medication cart. The note documented the bottle contained 50 ml, but it was unknown how much medication remained in the bottle before the resident took it. The agency nurse notified the provider and received orders to monitor the residents pulse and temperature every thirty minutes until 10:00 p.m. and obtain resident's full vital signs (blood pressure, temperature, pulse and respirations) every four hours and monitor the residents level of consciousness. The agency nurse contacted the family and all other pertinent parties of the incident.III. Staff interviewsLicensed practical nurse (LPN) #1 was interviewed on 4/8/26 at 4:38 p.m. LPN #1 said the medication cart was locked at all times and nothing was stored on top of the cart. She said she had recent education on medication storage and destruction. The DON was interviewed on 4/9/26 at 12:45 p.m. The DON said said a full investigation was completed after it was alleged Resident #44 ingested medications not prescribed to him. The DON said the facility assumed the resident had picked up the medication off the cart because the nurse left it unattended and left the unit. She said the nurse was terminated from the facility. She said the facility started medication audits and completed education to the nurses and the memory care staff which included keeping eyes on the residents at all times. The DON said the facility hired an additional activity assistant person and expanded the safety audits from weekly to daily. She said the medication should not have been left on the cart unattended.

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	065119	A. Building B. Wing	04/09/2026

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Valley Manor Care Center	1401 S Cascade Ave Montrose, CO 81401

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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 0700 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Try different approaches before using a bed rail. If a bed rail is needed, the facility must (1) assess a resident for safety risk; (2) review these risks and benefits with the resident/representative; (3) get informed consent; and (4) Correctly install and maintain the bed rail. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observations, record review and interviews, the facility failed to ensure accurate assessments, informed risks, and ongoing monitoring was in place for one (#74) of three residents with bed rails out of 36 sample residents.Specifically, the facility failed to:-Ensure a bed rail safety assessment was completed prior to the bed rail placement on Resident #74's bed; and, -Ensure less restrictive measures were attempted prior to the use of bed rails for Resident #74. Findings include:I. Resident #74A. Resident statusResident #74, age greater than 65, was admitted on [DATE] and discharged [DATE]. According to the April 2026 computerized physician's orders (CPO), diagnoses included restless leg syndrome, osteoporosis, macular degeneration, chronic kidney disease, atherosclerotic heart disease, chronic obstructive pulmonary disease (COPD), presence of urogenital implant, generalized anxiety disorder and chronic pain. The baseline care plan for Resident #74 revealed Resident #74 was dependent on staff for toileting, bathing, and transfer. Resident #74 required substantial assistance with footwear, upper and lower body dressing. B. Resident interview and observationsResident #74 was interviewed on 4/7/26 at 11:21 a.m. Resident #74 said she was staying at the facility on a respite stay, and planned to discharge home soon. Resident #74 said she had contractures to her left hand and fingers, but she was able to loop her hand around the quarter bedrail at her wrist and use the bed rail to reposition in bed. Resident #74 said a staff member installed the quarter bed rail a few days after she arrived at the facility on 4/1/26. Resident #74 said a staff member made sure the quarter bed rail was safe for use, but she did not remember which staff. Resident #74 said she would have liked another quarter bed rail on her right side to assist with repositioning in bed. Resident #74 said she was worried she could roll out of the bed when she turned toward the right without something to hold on to. During the interview, the bed rail was in place on the left side of the bed. C. Record reviewReview of Resident #74's CPO revealed the following orderLeft assist bar on bed for turning assistance, ordered 4/1/26. The 4/2/26 physical device data collection evaluation indicated the resident did not have any assistive devices. -However, per the director of nursing (DON) interview the bed rail was placed on the resident's bed on 4/3/26 and a new assessment was not completed (see interviews below). D. Staff interviewsThe nursing home administrator (NHA) and the DON were interviewed together on 4/9/26 at 3:41 p.m. The NHA said they identified the restorative program as an area for improvement prior to the survey. The NHA said they recently hired an ADON and one of the areas they planned for the ADON to manage once she was trained was the restorative program. The NHA said she reviewed the facility's internal messaging program and the it appeared the quarter bed rail for Resident #74's bed was installed on 4/3/26, after the assessment. The DON said once the assistive device was installed, a new assessment should have been completed by the nursing staff to ensure Resident #74 could use the device safely.