STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	065243	A. Building B. Wing	12/09/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Durango Health and Rehabilitation	2911 Junction St Durango, CO 81301

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 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. (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 0689 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observations, record review and interviews, the facility failed to ensure an environment free of accident hazards for one (#1) of three residents reviewed for accidents/hazards out of three sample residents. Specifically, the facility failed to prevent an elopement for Resident #1 on 9/16/25.Findings include:Record review and interviews confirmed the facility corrected the deficient practice prior to the onsite investigation on 12/8/25, resulting in the deficiency being cited as past noncompliance with a corrective action date of 10/1/25. I. Elopement incident on 9/16/25Resident #1 who was at risk for elopement, required distractions from wandering and structured activities.On 9/16/25 at 12:45 p.m. Resident #1 was observed at the nurses' station. At approximately 1:00 p.m. a certified nurse aide (CNA) noticed Resident #1 had received a room tray for lunch but the CNA was unable to locate the resident in his bedroom. At approximately 1:13 p.m. the nurse manager notified the interdisciplinary team (IDT) of a potential missing resident. At 1:15 p.m. an overhead page was made regarding the potential elopement of Resident #1. A search was initiated of the building, which included the common areas, rooms, closets, bathrooms, locked areas, the basement, outside areas, storage units, sheds and nearby vicinity around the facility.At approximately 2:25 p.m. the police department was notified of the missing resident. Resident #1 was located on 9/18/25 at approximately 2:00 p. m. He was found within a mile of the facility and had been missing for 49 hours. He was sent to the hospital, where it was noted he had abrasions and needed intravenous (IV) fluids.II. Facility's plan of correctionThe corrective action plan implemented by the facility in response to Resident #1's elopement on 9/16/25 was provided by the nursing home administrator (NHA) on 12/8/25 at 12:00 p.m. It revealed in pertinent part:A. Action to correct the deficient practice for Resident #1On 9/16/25, a full house audit of all elopement assessments was reviewed to ensure accuracy and to identify any other high-risk residents who needed additional interventions for safety. The nurse clinical resource educated the IDT on the following: -Completing documentation and ensuring that a resolution was clear and documented in the resident's electronic medical record (EMR); -How to pull progress note reports to be reviewed during the facility's morning meeting to address any concerns with resolution, and care plans were updated at the time of review that were resident-specific, which included triggers to identify behaviors before it escalated; -Non-pharmalogical interventions for the residents; -How to review new admission elopement/wander assessments to ensure assessments were completed correctly and that high risk residents had a care plan that was resident-specific;-New admission elopement/wander assessments were to be completed upon admission, quarterly and with a change of condition; and,-Care plans were reviewed and updated if there was a change to the elopement/wander score. All staff education on the elopement policy and procedure was initiated. A contract for a new wander guard system to be installed at the facility on 10/1/25. Once Resident #1 was located and returned to the facility he was going to be placed in the secured unit. B. Identify others at riskThe facility reviewed all other residents at risk for elopement and identified any resident with a high-risk score who was at risk for the alleged deficient practice. C. Systemic changesThe facility completed staff education on 9/19/25 in preventing resident elopement, emergency procedures for a missing resident and wandering and elopement policies and procedures.The staff development coordinator (SDC)/designee educated all staff on the presence of the door alarms, using the alarms and needing to check or investigate the doors and surrounding area outside if the door alarm sounds. An elopement drill was conducted on 9/19/25 for staff on all shifts and education was provided with any identified concerns.D. Ongoing monitoringThe NHA/designee was to monitor all admissions for elopement risk via reviewing their elopement wander user defined assessment during the daily clinical meetings Monday through Fridays, as well as the resident's care plan to ensure the resident-specific interventions were in place. The audits were documented via a spreadsheet and conducted for 12 weeks or until substantial compliance was achieved. The NHA/designee interviewed five staff members a week to identify residents that were at high risk for elopement or wandering. Any identified residents had their care plans reviewed to ensure resident-specific interventions were in place. Audits were documented via a spreadsheet and conducted for 12 weeks or until substantial compliance was achieved. The IDT reviewed daily progress notes for instances of exit-seeking and ensured appropriate interventions were put in place. Audits were documented via a spreadsheet and conducted for 12 weeks or until substantial compliance was achieved. All audits were reviewed in the facility's monthly quality assurance and improvement process (QAPI) meetings until substantial compliance