STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 065243	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 03/31/2026

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 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 record review, observations and interviews, the facility failed to ensure residents were kept free from abuse for one (#3) of six residents reviewed for abuse out of six sample residents.Specifically, the facility failed to protect Resident #3 and Resident #4 from physical abuse toward each other. Findings include:I. Facility policy and procedure The Abuse Prevention and Reporting Guidelines policy, revised June 2025, was provided by the interim nursing home administrator (NHA) on 3/31/26 at 5:07 p.m. The policy read in pertinent part, Residents will be free from verbal abuse, physical abuse, mental abuse, sexual abuse, involuntary seclusion, neglect, and exploitation. Residents will not be subjected to abuse by anyone, including, but not limited to, facility staff, other residents, consultants, or volunteers, staff or other agencies serving the residents, family members or legal guardians, friends, or other individuals. Any staff member who has reasonable cause to believe or reason to suspect any situation that may be considered abuse will immediately report to the charge nurse. The staff member will intervene and ensure that the resident is safe. Make sure that all residents are kept safe during the investigation. If a resident was the assailant, make sure that they are kept out of the reach of other residents and increase monitoring.II. Incident of resident-to-resident physical abuse between Resident #3 and Resident #4 on 11/26/25A. Facility investigation The 11/26/25 facility investigation was provided by the interim NHA on 3/31/26 at 10:30 a.m. The investigation revealed Resident #3 and Resident #4 resided in the memory care unit. The investigation documented the residents were observed to be frustrated and agitated with each other, as evidenced by their body language, per staff. Resident #3 had sustained a superficial scratch above his left eyebrow. The investigation determined Resident #4 might have made contact with Resident #3, causing the scratch. The staff member present was redirecting another resident to his room at the time of the incident and overheard the residents' elevated voices and defensive body language. The investigation documented the staff member observed the residents moving their arms as if they were going to hit each other, but the staff member did not see contact made. The investigation documented the residents were unable to provide information regarding the incident due to their cognitive status. The investigation documented psychosocial checks were completed for both residents for 72 hours. The residents' physicians and responsible parties were notified. The investigation documented the facility substantiated the physical abuse. B. Observations On 3/30/26 at 9:30 a.m. Resident #3 was walking around the unit, going in and out of other residents' rooms. Resident #3 walked up to Resident #4, who sat in a chair, and then Resident #3 turned around and walked away. The staff redirected Resident #3 when he was too close to Resident #4.C. Resident #3 (victim)1. Resident status Resident #3, age [AGE], was readmitted on [DATE]. According to the March 2026 computerized physician orders (CPO), diagnosis included Alzheimer's disease and schizophrenia. The 3/23/25 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. He required maximum assistance with activities of daily living (ADL). 2. Record review Resident #3's care plan, updated 8/25/25, revealed the resident was at risk for resident-to-resident altercations related to individuals invading his space. The care plan (continued on next page)

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

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

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F 0600 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	documented he was at risk for re-traumatization, his anxiety was triggered by male caregivers, or those he perceived to be male. Pertinent interventions included providing an opportunity for positive interaction, attention and stopping and talking with the resident while passing by. The skin assessment, dated 11/26/25, revealed Resident #3 had a left eyebrow scratch. D. Resident #4 (assailant) 1. Resident statusResident #4, age [AGE], was admitted on [DATE]. According to the March 2026 CPO, diagnoses included Lewy body dementia, hypertension and depression.The 2/7/26 MDS assessment revealed the resident was severely cognitively impaired with a BIMS score of 0 out of 15. He required maximum assistance with ADLs. The MDS assessment indicated the resident did not have behaviors directed towards others. 2. Record review Resident #4's behavior care plan, dated 1/14/25, revealed the resident was at risk for the potential to demonstrate verbally abusive behaviors. The care plan documented he had the potential for psychosocial issues due to an incident of receiving unprovoked agitation with physical abuse from another resident. Pertinent interventions included monitoring the resident for signs and symptoms of aggression as well as signs and symptoms of fear or psychosocial trauma, documenting behavior and attempted interventions and reporting physical contact from another resident. Resident #4's antipsychotic medication care plan, dated 7/2/25, revealed the resident was at risk for aggressive behaviors. Pertinent interventions included monitoring for aggressive behaviors, such as throwing medications, cursing at others, and non-redirectable agitation and if agitation was observed, intervening immediately to prevent an increase in behaviors.III. Staff interviews Registered nurse (RN) #1 was interviewed on 3/30/26 9:10 a.m. RN #1 said there was one staff member on the unit for seven residents. She said at times it was hard, as she tried to complete personal care with the residents and keep an eye on them too. She said she had seen residents get into each other's space and fights did occur. Certified nurse aide (CNA) #1 was interviewed on 3/31/26 at 9:15 a.m. CNA #1 said she was the only staff member who worked on the unit for seven residents. She said it was very hard at times, especially when the residents had moods,' which was pretty often. She said when the residents' behaviors increased, it was harder. She said the cares were easy to complete, except for Resident #3, who urinated all over the place. CNA #1 said she followed him around all day with the mop bucket. She said she left him alone often and let him do his thing because he was known to hit staff and get aggressive. She said he was not aggressive toward other residents, but he did get in their space often. She said Resident #4 did not like it when others got in his space. She said she had seen Resident #3 and Resident #4 get into a fist fight on 11/26/25. The director of nursing (DON) was interviewed on 3/31/26 at 12:45 p.m. The DON said she was involved with abuse investigations. She said the incident between Resident #3 and Resident #4 on 11/26/25 was substantiated because of the injury for Resident #3. She said the facility monitored and redirected residents away from each other as part of the interventions for safety.