

Department of Health & Human Services
Centers for Medicare & Medicaid Services

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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 07/30/2026
NAME OF PROVIDER OR SUPPLIER Durango Health and Rehabilitation		STREET ADDRESS, CITY, STATE, ZIP CODE 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 0684 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide appropriate treatment and care according to orders, resident's preferences and goals. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on record review and interviews, the facility failed to ensure one (#13) of five residents received treatment and care in accordance with professional standards or practice out of 48 sample residents. Specifically, the facility failed to:-Complete a timely assessment after Resident #13 experienced altered mental status; and,-Ensure an antibiotic was started in a timely manner for Resident #13. Findings include:I. Facility policy and procedureThe Change Of Condition Reporting policy, revised October 2020, was provided by the nursing home administrator (NHA) on 7/31/26 at 8:25 a.m. It revealed in pertinent part, Any sudden or serious change in a resident's condition manifested by a marked change in physical or mental behavior will be communicated to the physician with a request for physician visit promptly and/or acute care evaluation. The licensed nurse in charge will notify the physician. Document resident change of condition and response in nursing progress notes, on 24-Hour report or dashboard and update resident care plan, as indicated in clinical meeting. All attempts to reach the physician and responsible party will be documented in the nursing progress notes. Documentation will include time and response.II. Resident #13A. Resident statusResident #13, age [AGE], was admitted on [DATE] and discharged to the hospital on 7/27/26. According to the July 2026 computerized physician orders (CPO), diagnoses included non-alcoholic steatohepatitis (NASH - non-alcohol induced liver failure), hepatic encephalopathy (swelling around the brain), muscle weakness, back pain, osteoarthritis, hypertension, ascites, edema, and chronic kidney disease. The 7/7/26 minimum data set (MDS) assessment revealed Resident #13 was cognitively intact with a brief interview for mental status (BIMS) score of 15 out of 15. Resident #13 required substantial assistance with bathing, lower body dressing and repositioning. Resident #13 required moderate assistance with toileting, personal hygiene, upper body dressing and transfers. B. Resident's representative interviewResident #13's representative was interviewed on 7/28/26 at 10:21 a.m. The representative said Resident #13 was in the hospital with altered mental status at the time of the interview. The representative said Resident #13's liver was failing and she was hospitalized recently from 7/17/26 to 7/25/26, but had to be hospitalized again on 7/27/26. The representative said she heard Resident #13 was starting to have confusion on the morning of 7/27/26 from a friend visiting Resident #13. She said she went to visit Resident #13 early in the afternoon, at approximately 1:30 p.m., and Resident #13 appeared confused during her visit. The representative said at first Resident #13 was just disoriented, but she felt the resident was getting worse as the afternoon progressed, until Resident #13 could no longer answer questions appropriately and did not understand how to use her call light for help. The representative said Resident #13 was also intermittently calling out and she thought Resident #13 was in pain. Resident #13's representative said the resident's confusion seemed similar to the previous time Resident #13 was hospitalized for encephalopathy (on 7/17/26) and she told the floor nurse. The representative said the floor nurse argued with her when she (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
FORM CMS-2567 (02/99) Previous Versions Obsolete	Event ID:	Facility ID: 065243 If continuation sheet Page 1 of 5

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F 0684 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	7/28/26 at 2:46 p.m. The NP said she was the provider taking calls for the facility on 7/27/26. The NP said she was not aware Resident #13 was transferred to the local area emergency room at the time of the interview. The NP said she had been visiting residents at the facility earlier in the day, but was not at the facility when Resident #13 was transferred to the local area hospital. The NP said she found a notification from the facility regarding the physician's order change request for the rifaximin in her notes, and the notification had a reply that the medical director sent a new order this morning (7/28/26). The NP said she did not remember receiving a call about Resident #13 having a change in condition or requesting transfer to the hospital. The NP said she could not find a missed call or notification from the facility around 6:00 p.m., the approximate time Resident #13 transferred to the hospital on 7/27/26. The NP said she managed hundreds of residents across multiple facilities and it was common for her to receive multiple notifications from the facility at once; so she may have forgotten if she was notified some other way. Registered nurse (RN) #3 was interviewed on 7/28/26 at 3:27 p.m. RN #3 said she had worked at the facility for a year and a half, mostly as a licensed practical nurse (LPN), but she had recently obtained her RN license. RN #3 said she was Resident #13's nurse on the morning shift of 7/27/26. RN #3 said when Resident #13 was first admitted to the facility, she was alert and oriented, but Resident #13 started having episodes of confusion and disorientation as her liver failure progressed. RN #3 said when she assessed Resident #13 in the morning on 7/27/26, Resident #13 was confused, but able to follow directions and was able to take the two doses of lactulose scheduled during her shift along with her other medications. RN #3 said she held the scheduled rifaximin because she heard in report a previous nurse checked the emergency medication dispensing system and none were stocked, and the pharmacy said the medication was on back order. RN #3 said because of Resident #13's recent hospitalization, she charted the confusion and disorientation as chronic because she thought they were her new baseline after returning from the hospital. RN #3 said she was not aware Resident #13 was assessed to be alert and oriented upon readmission to the facility on 7/25/26. RN #3 said if the resident or family reported a change in condition, a LPN should obtain vital signs and then notify the charge nurse or nurse manager to complete a formal assessment while contacting the provider. The medical director was interviewed again on 7/29/26 at 2:30 p.m. The medical director said he was not aware Resident #13 had not received any doses of the ordered rifaximin prior to her hospitalization, but he did not think that the missing doses caused the hospitalization because rifaximin did not work that quickly in helping manage liver failure. The medical director said the primary intervention for managing Resident #13's liver failure was the scheduled lactulose, which was being given as ordered, but was less effective as the liver failure worsened. The medical director said Resident #13's liver failure had been progressing to the end stage over the last month, evidenced by the previous hospitalization, but the resident and the family were not ready to transition to hospice care services during the last care conference. The medical director said if he was the provider the facility was supposed to call on 7/27/26, he would have sent Resident #13 to the hospital. The medical director said other than failing to meet the regulatory requirement of notifying the provider in a timely manner, he had no issues with the care provided or the nurses decision to transfer Resident #13 to the local area hospital. The director of nursing (DON) and the NHA were interviewed together on 7/30/26 at 11:27 a.m. Both the DON and the NHA remembered when Resident #13 transferred back to the hospital on 7/27/26. The DON and the NHA both said they thought the floor nurse on duty contacted the NP. The DON said after reviewing Resident #13's EMR, she could not find any documentation of a change in condition assessment or provider notification. The DON said she was able to find documentation of an oxygen saturation assessment around 12:00 p.m. that day (7/27/26), but could not find any documentation of vital signs (continued on next page)		

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F 0684 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	taken at the time of the resident's transfer to the hospital. The NHA said normally the nurses did not miss documentation like this. The NHA said the facility used a whiteboard to track transfers, falls, and other incidents. The NHA said normally the DON or the NHA reviewed the residents' EMRs to ensure the event was documented correctly, as well as contacting the nurse for more information about the incident, but they had not been able to review the white board during the survey.		