STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	065306	A. Building B. Wing	09/11/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Valley Rehabilitation and Healthcare Center, The	211 E 3rd Ave Mancos, CO 81328

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 0573 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Let each resident or the resident's legal representative access or purchase copies of all the resident's records. (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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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0573 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Based on record review and interviews, the facility failed to ensure a copy of medical records were provided timely for one (#1) of two residents out of seven sample residents.Specifically, the facility failed to ensure medical records were provided timely upon request to Resident #1's representative.Findings include:I. Facility policy and procedure The Release of Information policy, revised November 2009, was provided by the clinical regional director on 9/10/25 at 3:21 p.m. The policy read in pertinent part, The resident may initiate a request to release such information contained in his or her records and charts to anyone he or she wishes. Such requests will be honored only upon the receipt of a written, signed, and dated request from the resident or representative. A resident may obtain photocopies of his or her records by providing the facility with at least a 48 hour advance notice of such request. II. Resident representative interviewResident #1's representative was interviewed on 9/10/25 at 2:09 p.m. The representative said she requested Resident #1's medical records from the facility but had never received them after multiple requests. She said she signed the authorization for release form on 7/11/25 and provided the form to the nursing home administrator (NHA). She said she later received a call from the social service director (SSD) that Resident #1's medical records were ready, but the file was very large and she needed to know how the representative wanted it to be sent to her. The resident's representative said she called the facility and spoke to the business office manager (BOM). She said she asked for Resident #1's last two months of physician's orders and labs to be emailed to her. The resident's representative said she called the facility again on 8/5/25 and told the SSD that she still had not received the records and wanted them emailed to her. III. Record reviewThe authorization for release of protected health information (PHI) form for Resident #1 was provided by the medical records director on 9/10/25 at 1:20 p.m. The PHI authorization release form for Resident #1 identified that a request for the resident's medical records was signed on 7/11/25. The form did not identify when the representative received the medical records or when the medical records were sent to the representative. -Review of Resident #1's electronic medical record (EMR) identified that the spelling of the resident representative's name in her email address was spelled incorrectly on the contact list. IV. Staff interviewsThe medical records director was interviewed on 9/10/25 at 12:20 p.m. The medical records director said when a resident or their representative requested medical records, they needed to submit an authorization for release form for the medical records. The medical records director said the facility had 30 days to gather the medical records and send them to the requester. She said Resident #1's medical records were requested by his representative on 7/11/25. The medical records director said she had the resident's medical records ready on 7/17/25. The medical records director said she did not know in what format the representative wanted the files to be sent to her so the SSD followed up with Resident #1's representative. The SSD was interviewed on 9/10/25 at 2:51 p.m. The SSD said she emailed the requested medical records to Resident #1's representative on 7/21/25. She said she used the email address on the resident's EMR contact list.-However, the resident representative's name was misspelled in the email address listed on the resident's EMR contact list (see record review above). The NHA and the BOM were interviewed together on 9/10/25 at 3:05 p.m. The NHA compared the email address she had for Resident #1's representative with the email address on the resident's EMR contact list and said the representative's email address was documented incorrectly on the contact list. She said it was facility's error and she would make sure Resident #1's received all requested medical records to the appropriate email address. The BOM said she would update Resident #1's EMR contact list with the representative's correct email address. The NHA said she would make sure that any new resident/resident representative contact information would be provided to the facility in writing and then added to the resident's EMR. The NHA was interviewed again on 9/10/25 at 3:25 p.m. The NHA said the facility tried to send medical record requests within 48 hours, excluding holidays and weekends, but believed the facility had 30 days to send the medical records. The NHA reviewed the medical record policy and said the facility should have provided the medical records to Resident #1's representative within 48 hours. She said to help with the timeliness of medical records requests, she would educate the medical records director on the appropriate timeline. She said the facility would conduct an audit of all of the residents' EMR contacts to ensure the facility had accurate records for the contact information for residents' representatives. The medical records director was interviewed again on 9/11/25 at 10:34 p.m. The medical records director said the NHA informed her that the facility's policy stated the facility should provide medical record requests to the resident's representative within 48 hours after the receipt of the PHI authorization release form. The medical

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F 0657 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Develop the complete care plan within 7 days of the comprehensive assessment; and prepared, reviewed, and revised by a team of health professionals. (continued on next page)

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F 0657 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 record review and interviews, the facility failed to ensure care plans were revised and appropriate for three (#1 and #3) of four residents reviewed for comprehensive care plans out of seven sample residents. Specifically, the facility failed to:-Ensure Resident #1's fall care plan was revised to include new interventions if needed to assist in the prevention of falls for 11 out the resident's 13 falls between 1/17/25 and 6/27/25; and,-Ensure Resident #3's care plan was revised to include new interventions if needed after the resident fell on 7/27/25.Findings include:I. Facility policy and procedure The Falls-Clinical Protocol policy, revised March 2018, was provided by the nursing home administrator (NHA) on 9/10/25 at 8:01 p.m. via email. According to the fall policy, the staff and the physician would identify pertinent interventions to try to prevent falls and to address the risks of clinical significant consequences of the falls. The policy identified the staff would try various relevant interventions based on the assessment of the nature of the fall until the falls were reduced, stopped or a reason for the fall continuation. The policy documented the staff would continue to monitor and document the individual's response to the interventions intended to reduce the falls or the consequence of falls.The Care Plans, Comprehensive Person-Centered policy, revised March 2022, was provided by the NHA on 9/11/25 at 3:21 p.m. The policy read in pertinent part, A comprehensive, person-centered care plan that includes measurable objectives and timetables to meet the resident's physical, psychosocial and functional needs is developed and implemented for each resident. The interdisciplinary team (IDT), in conjunction with the resident and his/her family or legal representative, develops and implements a comprehensive person-centered care plan for each resident. The care plan interventions are derived from a thorough analysis of the information gathered as part of the comprehensive assessment. When possible, interventions address the underlying sources of the problem areas, not just symptoms or triggers. Assessments of residents are ongoing and care plans are revised as information about the resident and the resident's condition changes. The IDT reviews and updates the care plan when there has been a significant change in the resident's condition; when the desired outcome is not met; when the resident has been re-admitted facility from a hospital stay; and, at least quarterly in conjunction with required quarterly minimum data set (MDS) assessments.II. Resident #1A. Resident statusResident #1, age greater than 65, was admitted on [DATE] and discharged to the hospital on 6/27/25. According to the June 2025 computerized physician orders (CPO), diagnoses included adult failure to thrive, unspecified dementia, severe with mood disturbance, generalized muscle weakness, difficulty in walking, unsteadiness on feet, other abnormalities of gait and mobility, need for assistance with personal care, repeated falls, and reduced mobility.The 6/15/25 MDS assessment documented the resident had severe cognitive impairment with a brief interview for mental status (BIMS) score of three out of 15. The MDS assessment documented Resident #1 used a wheelchair for mobility, required substantial staff assistance to sit to stand and partial to moderate staff assistance to transfer to and from a bed/chair/wheelchair. The MDS assessment revealed the resident had had two or more falls that included injury since his admission. According to the MDS assessment, the resident had a history of wandering but his wandering did not put him at risk to be in a dangerous place. B. Resident representative interviewResident #1's representative was interviewed on 9/10/25 at 2:08 p.m. The representative said that Resident #1 had multiple falls at the facility and was sent to the hospital after his last fall on 6/27/25. C. Record reviewThe fall care plan, initiated 7/26/23, revised 7/3/25 (after the resident transferred to hospital on 6/27/25 and discharged from the facility) identified Resident #1 was at risk for falls related to cognition, dementia, poor safety awareness and weakness. The intervention, initiated 3/21/25, directed staff to place bed cane to my bed to assist with self positioning and independence. The intervention, initiated 3/27/25, directed staff to place grip tape on the bathroom floor. The Kardex report (a tool utilized to provide staff with instructions for resident care) documented the resident had had falls with injury. -The Kardex did not include interventions to help prevent additional falls. A nursing falls documentation form, dated 1/17/25, documented that Resident #1 experienced an unwitnessed fall at 4:15 p.m. The form documented Resident #1 fell out of his wheelchair on his way to the dining room on 1/17/25. The resident sustained small abrasions/scratches to both of his knees. The 1/7/25 wound evaluation note documented Resident #1 had scattered abrasions on his knees and above his right eyebrow. A nursing falls documentation form, dated 1/17/25, documented that Resident #1 experienced an unwitnessed fall at 7:00 p.m. The form documented Resident #1 wandered into another resident's room, became confused and fell to