| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: | (X2) MULTIPLE CONSTRUCTION | (X3) DATE SURVEY COMPLETED |
|---|---|---|---|
| | 065306 | A. Building<br>B. Wing | 12/10/2025 |

| NAME OF PROVIDER OR SUPPLIER | STREET ADDRESS, CITY, STATE, ZIP CODE |
|---|---|
| Valley Rehabilitation and Healthcare Center, The | 211 E 3rd Ave<br>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 0689<br><br>Level of Harm - Actual harm<br><br>Residents Affected - Few | Ensure that a nursing home area is free from accident hazards and provides adequate supervision to prevent accidents.<br><br>(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<br><br>Level of Harm - Actual harm<br><br>Residents Affected - Few | **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on interviews, record review and observations, the facility failed to ensure residents were free from accidents or hazards for one (#1) of three residents reviewed out of seven sample residents. Specifically, the facility failed to ensure Resident #1 was provided transportation, by use of the facility vehicle, without injury. Resident #1, was admitted on was admitted on [DATE], with diagnoses of dementia, mild, with other behavioral disturbances, age-related osteoporosis without current pathological fracture, muscle weakness, difficulty walking, abnormalities of the gait and mobility, need for assistance with personal care and adult failure to thrive. On 9/15/25 the resident was being transported to an appointment outside of the facility. Activities assistant (AS) #1 had to abruptly stop, which caused Resident #1's seatbelt to become unfastened and Resident #1 fell out of her wheelchair. Resident #1 sustained a fracture of her left femur which required surgery. Findings include:Record review, observations and interviews confirmed the facility corrected the deficient practice related to an accident with a facility vehicle during transport that resulted in Resident #1 being injured and hospitalized prior to the onsite investigation on 11/4/25 to 11/5/25. The deficiency was cited as past non-compliance with a correction date of 9/24/25.I. Incident on 9/15/25The 9/15/25 reported facility investigation for equipment malfunction read in part: The transport driver/activity aide was taking the resident to an appointment. During this transport, the transport driver needed to make a hard, sudden stop to prevent an accident. The resident, who had a seat belt on, then fell out of the wheelchair. Based on investigation by the corporate official and the maintenance director, the seatbelt appeared to be locked and secure. Under force, the seatbelt came loose. The transport driver was placed on driving suspension until the investigation was complete. The vehicle was placed out of commission until repaired and passed a safety inspection. All other transport vehicles not related to this incident was also inspected for potential safety issues. No issues were found with the other vehicles.According to the investigation, the resident was taken to the emergency room for evaluation.The 9/15/25 police incident report was provided by the nursing home administrator (NHA) on 11/4/25 at approximately 3:50 p.m. The incident report identified a police officer received a call on 9/15/25 regarding a traffic incident that resulted in an injury to a passenger. According to the report, the reporting party stated that she worked for the facility and was transporting a resident when a car in front of her hit the brakes, stopping abruptly, causing her to hit her brakes abruptly. The passenger in the back of the vehicle, who was seated in a wheelchair, was ejected from the chair, causing an injury to her knee. The reporting party stated the resident was flown out due to the injuries. A 9/24/25 written statement from the plant operations director was provided by the NHA 11/4/25 at approximately 3:50 p.m. The statement read, When the initial investigation was communicated to the NHA and the plant operations director from the maintenance director, it was thought that the end of the seatbelt that was used (during the 9/15/25 incident) was the [NAME] manufactured end, placed into the external seatbelt end, from the Q-straight belt. Upon further investigation and reenactment from the driver, it was determined that the end of the van seatbelt that was supposed to attach to the Q-straight, was used to latch the resident in. The driver was interviewed and she thought the seatbelt was fully secure. During the investigation it was also determined that the [NAME] manufactured ends were not compatible with the external seatbelt from Q-straight. The non-compatible ends of the [NAME] seat belts were disabled from use and new seat belts were ordered. The van was placed out-of-order until the new seatbelts arrived. The 9/24/25 amendment of the facility's final report was provided by the NHA on 11/4/25 at approximately 3:50 p.m. The amendment read, Upon further investigation, the facility found the transport driver latched non-compatible ends of the seat belt together to cause the malfunction. Non-compatible ends are no longer accessible to prevent a reoccurrence. Daily safety inspections of the vehicle will be formed by the transport driver or designee for proper seat belt latching. II. Facility plan of correctionThe plan of correction was provided by the NHA on 11/4/25 at 11:57 a.m. A. Immediate action to correct the deficient practice The plan of correction documented the transport drivers were all re-education to ensure competency on safe transportation. The drivers were not allowed to drive until they successfully passed the competency review. The driver competency audit began on 9/15/25 related to the 9/15/25 incident. The corporate plant operations director reviewed the vehicle for proper safety restraints in place to transport residents on 9/24/25. Through the investigation it was found that the driver involved in the 9/15/25 incident latched non-compatible ends of the seat belt together to cause the malfunction. The non-compatible ends were removed from the vehicle to prevent a reoccurrence of the |