STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	065384	A. Building B. Wing	05/07/2026

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Yampa Valley Healthcare Center	943 W 8th Dr Craig, CO 81625

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 - Actual harm Residents Affected - Few	Ensure that a nursing home area is free from accident hazards and provides adequate supervision to prevent accidents. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on record review and interviews, the facility failed to ensure residents were kept free from accidents or hazards for one (#3) of two residents out of six sample residents.Resident #3, was admitted on [DATE] with diagnoses of cerebral vascular disease (CVA), and diabetes. Resident #3 was dependent on staff assistance for transfers using a Hoyer lift (mechanical lift). On 10/28/25, the staff were transferring Resident #3 from her bed to the shower chair using the Hoyer lift. The Hoyer lift sling came unhooked from the Hoyer lift during the transfer, which resulted in Resident #3 falling to the floor. The resident hit her head when she fell and was transferred to the hospital for evaluation. At the hospital, the resident was diagnosed with an acute parafalcine subdural hematoma (blood accumulation on the brain).Specifically, the facility failed to transfer Resident #3 safely, which resulted in the resident sustaining a brain injury. Findings include:Record review and interviews confirmed the facility corrected the deficient practice prior to the onsite investigation on 5/6/26 to 5/7/26, resulting in the deficiency being cited as past non-compliance with a correction date of 10/30/25.I. Incident on 10/28/25On 10/28/25, staff were transferring Resident #3 using the Hoyer lift. The staff failed to use the Hoyer lift properly, resulting in the lift sling coming unhooked. Resident #3 fell to the floor and sustained an acute parafalcine subdural hematoma. II. Facility plan of correctionThe plan of correction the facility implemented in response to Resident #3's fall on 10/28/25 was provided by the director of nursing (DON) on 5/6/26 at 3:45 p.m. The plan of correction documented the following. A. Immediate action to correct the deficient practice On 10/29/25, the facility conducted an investigation of Resident #3's fall. The facility interviewed all staff who were on duty when the resident fell and all staff who were involved in care for the resident on the day of the fall and a few days prior to the fall.On 10/29/25, the facility completed an inspection of the mechanical lift and determined the lift worked correctly with no imperfections.On 10/29/25, the facility interviewed staff and all staff reported the mechanical lift was functioning well.B. Identification of other residentsOn 10/29/25, the facility completed an audit and identified one other resident in the building who used the mechanical lift and was at risk for falls. C. Systemic changesOn 10/28/25 audits were initiated to verify the mechanical lift and the slings to have no defects for fall prevention interventions.On 10/29/25 and 10/30/25, nursing leadership re-educated all nursing staff in regards to reviewing the residents' care plans and Kardex's (staff directive tool), as well as the importance of following and implementing interventions outlined in these documents in an effort to reducethe risk of falls for facility residents. The DON completed competencies for the certified nurse aide (CNA) #4 and CNA #5 from the incident on 10/29/25.D. MonitoringThe DON and or designee was responsible for spot checking care staff during resident transfers who used the mechanical lift monthly.The maintenance director completed an audit of the mechanical lift monthly. Interviews and record review during the investigation revealed corrective actions to identify the resident and other residents who had the potential to be affected by the deficient practice, systematic changes to prevent its recurrence, and monitoring to ensure sustained corrections were in place.III. Facility policy and procedureThe Accident and Incident Investigating and Reporting policy, dated July 2017, was (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

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	065384	A. Building B. Wing	05/07/2026

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Yampa Valley Healthcare Center	943 W 8th Dr Craig, CO 81625

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 - Actual harm Residents Affected - Few	provided by the DON on 5/7/26 at 11:10 a.m. It read in pertinent part, All accidents or incidents involving residents, employees, visitors, and vendors occurring on our premises shall be investigated and reported to the administrator. The nurse supervisor or charge nurse shall promptly initiate and document investigation of the accident or incident. The following data as applicable shall be included on the Report of Incident/Accident form. The date and time the accident or incident took place, the nature of the injury, the circumstance surrounding the accident, where the accident took place, the name of witness (s), the injured person account of the accident, the time the injured person's physician was notified and the family, the condition of the injury and disposition of the injured. Any corrective action taken place after the incident with follow up and any other pertinent information.The Lifting Machine, using a Mechanical Lift Policy, dated July 2017, was provided by the DON on 5/7/26 at 11:10 a.m. It read in pertinent part, At least two nursing assistants are needed to safely move a resident with a mechanical lift. Mechanical lifts may be used for tasks that require: lifting a resident off the floor or transferring a resident from bed to chair. Lift design and operation vary across manufactures. Staff must be trained and demonstrate competency using the specific machines or devices in the facility.IV. Resident #3A. Resident statusResident #3, age [AGE], was admitted on [DATE] and readmitted on [DATE]. According to the May 2026 computerized physician orders (CPO), diagnoses included subdural hematoma (buildup of blood on the surface of the brain or brain injury), cerebral vascular disease (CVA) and diabetes. The 2/4/26 minimum data set (MDS) assessment revealed the resident was moderately cognitively impaired with a brief interview for mental status (BIMS) score of 11 out of 15. The resident was dependent on staff assistance for activities of daily living (ADL) and a mechanical lift was required for transfers. B. Record reviewThe nurse note, dated 10/28/26 at 10:31 a.m., revealed Resident #3 fell from the Hoyer lift during a staff-assisted transfer. The note documented the resident sustained visible injuries to her face and left arm. The nurse called for emergency transport and the resident left the facility via ambulance at 10:07 a.m.The fall investigation report, dated 10/28/25 at 9:36 a.m., revealed Resident #3 was being transferred in the Hoyer lift from the bed to the shower chair when one of the straps on the Hoyer lift sling came off of the Hoyer lift hook and the resident fell to the floor of her room. The resident sustained a laceration to her forehead. Emergency medical services (EMS) were called to have the resident transported and assessed at the emergency room (ER). At 2:20 p.m. the facility was notified the resident had an acute subdural hematoma along a portion of the falx cerebri (part of the brain).The hospital records, dated 10/28/25, revealed Resident #3 presented to the hospital via helicopter after a fall out of a mechanical lift on 10/28/25. Initial imaging on 10/28/25 revealed an acute parafalcine subdural hematoma. The documentation revealed neurosurgery was consulted and the resident was admitted to the hospital for monitoring. The hospital records, dated 10/29/25, revealed a repeat CAT scan (computed axial tomography - image of the brain) was completed on 10/29/25 which showed improvement and the resident could be discharged back to the facility. The risk for falls related to a cerebral vascular disease care plan, revised on 11/16/25, revealed Resident #3 was at risk for falls. Pertinent interventions included educating the resident, family and caregivers about safety reminders and what to do when a fall occurred. The ADL self care performance care plan, revised 11/16/25, documented the resident required a Hoyer lift (with two-person assistance for transfers. V. Staff interviewsCNA #1 was interviewed on 5/6/26 at 3:45 p.m. CNA #1 said Resident #3 used the mechanical Hoyer lift for transfers. He said he was recently provided education on how to transfer residents with the lift safely.CNA #2 was interviewed on 5/6/26 at 2:30 p.m. CNA #2 said Resident #3 required the use of the Hoyer lift for transfers. She said when transferring a resident with a Hoyer lift, two caregivers were needed. She said Resident #3 fell out of the lift last year (2025). She said the facility had all the caregivers read a packet on how to transfer residents. She said they talked about the fall in a staff meeting as well. Registered nurse (RN) #1 was interviewed on 5/7/26 at 9:10 a.m. RN #1 said Resident #3 fell out of the mechanical lift last year (2025). She said she was the nurse present during the fall and completed the assessment. She said the lift sling hook fell out the hook (continued on next page)

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	065384	A. Building B. Wing	05/07/2026

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Yampa Valley Healthcare Center	943 W 8th Dr Craig, CO 81625

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 - Actual harm Residents Affected - Few	(holster) when the CNAs moved the resident to try and position her into the shower chair. RN #1 said the resident fell onto the floor and hit her head. She said she called EMS and sent Resident #3 to the hospital to be assessed further. She said she was part of educating the CNAs on transferring residents with the Hoyer lift and completed the training before the resident came back from the hospital a few days later. The maintenance director was interviewed on 5/7/26 at 9:50 a.m. The maintenance director said when Resident #3 fell on [DATE] he examined the mechanical lift immediately and found the lift to be working correctly. The DON was interviewed on 5/7/26 at 11:50 p.m. The DON said Resident #3 fell from the mechanical lift when the CNAs shifted the resident in the sling for positioning into the shower chair. She said the loop of the sling came off the hook which caused the resident to tip and fall to the ground. The DON said the resident was sent to the hospital. She said she immediately started an investigation and found the lift was working correctly and the sling had no rips or deformities. She said she educated the care staff within the next two days (10/29/25 and 10/30/25) on transferring with the Hoyer lift and watched the two CNAs who were present when Resident #3 fell do a transfer while she observed them. She said the facility continued to audit the Hoyer lift. She said she regularly looked for any rips or deformities with lift slings. She said she completed spot checks for transferring residents. She said Resident #3 sustained a brain injury from the incident. She said she continued to educate the staff and work with staff to ensure care planned interventions were being followed for the residents' safety.