

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  065306	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED  12/10/2025
NAME OF PROVIDER OR SUPPLIER  Valley Rehabilitation and Healthcare Center, The		STREET ADDRESS, CITY, STATE, ZIP CODE  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 0689  Level of Harm - Actual harm  Residents Affected - Few	<p>Ensure that a nursing home area is free from accident hazards and provides adequate supervision to prevent accidents.</p> <p><b>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY**</b> 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</p> <p>(continued on next page)</p>		

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:  065306	Facility ID:  065306  If continuation sheet Page 1 of 4

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<p>F 0689</p> <p>Level of Harm - Actual harm</p> <p>Residents Affected - Few</p>	<p>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 incident. The van involved in the incident was placed out of commission on 9/24/25.The transport driver training checklists for seven staff members trained to transport residents were provided by the NHA on 11/4/25 at 12:20 p.m. The trainings identified the staff members, including AS #1 were trained on how to complete a facility vehicles inspection; adjust the mirrors; inspect the wheelchair, the use of the ramps, use of the hydraulic lift, how to operate the hydraulic lift with two people, properly securing a passenger with a seatbelt; acknowledgment of emergency procedures; and, how to drive an oversized vehicle. The training identified the education was conducted beginning on 9/15/25. A photo packet for training was provided by the NHA on 11/4/25 at approximately 3:50 p.m. The photos identified the correct way to secure a wheelchair on the mini van. B. Systematic changesThe plan of correction identified the implementation of systematic changes to prevent a reoccurrence. The facility implemented daily safety inspections of the vehicle by the transport driver or designee to ensure proper seat belt latching. The daily inspections would be documented on a quality assurance and plan of improvement (QAPI) checklist form. According to the plan of correction, the transport drivers would be evaluated every six months for proper safety procedures for resident transports. Vehicle safety inspection reports and checklists were provided by the NHA on 11/4/25 at 12:20 p.m. The checklists identified the vehicle and securements were inspected daily between 9/24/25 and 11/4/25 when in use. The 9/24/25 inspection report noted there was a missing end of a seatbelt restraint on the mini van and the vehicle would be out of use until the new belt arrived.C. MonitoringThe plan of correction documented the monitoring action following the incident. The maintenance director would bring the prior weeks' vehicle inspections to the NHA every Monday. The inspections would be then reviewed by the NHA with the IDT during the QAPI meetings to ensure that sufficient practice had been corrected. The QAPI review would continue over the following six months. III. Facility policy and procedureThe Transporting of Resident (Facility Van), undated, was provided by the NH on 11/5/25. The policy read in pertinent part, It is the policy of the facility to provide residents safe, non-emergency transportation to doctor's appointments</p> <p>(continued on next page)</p>		

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F 0689  Level of Harm - Actual harm  Residents Affected - Few	<p>9/15/25 hospital notes identified the resident sustained skin tears, left lower thigh pain, swelling and a left distal femur fracture with intercondylar extension after a fall from her wheelchair. According to the hospital notes, the resident underwent surgery as a result of the fracture. The 9/16/25 interdisciplinary team (IDT) note documented Resident #1 was in the facility vehicle, secured by the seat belt to the vehicle, when the driver came to an abrupt stop. The sudden stop caused the resident to fall out of the wheelchair and land on the floor of the vehicle. The note indicated Resident #1 was immediately transported to hospital after the incident. The note revealed maintenance evaluated the seat belt and determined the seat belt was faulty and the vehicle would be placed out of commission while the seat belt was repaired. V. Staff interviews The NHA and the corporate plant operations director were interviewed together on 11/4/25 at 3:10 p.m. The NHA said AS #1 was interviewed after the 9/15/25 incident. AS #1 said a motorcycle pulled out into traffic causing her to have to stop suddenly. The plant operations director said AS #1 was driving the facility's mini van when she was cut off in traffic. The NHA said Resident #1 was no longer an employee at the facility as a personal choice, which was not related to the 9/15/25 incident. The plant operations director said he reviewed the vehicle involved in the incident to try to determine why the seatbelt did not hold Resident #1 in her wheelchair when the AS #1 made a sudden stop. He said he had AS #1 demonstrated to him how she secured the resident on 9/15/25. The plant operations director said when AS #1 attempted to secure the resident in the vehicle on 9/15/25, she thought she had done everything correctly but during the replay demonstration, after the incident, she realized she used the wrong seat belts components to secure Resident #1. He said the lack of proper securement was an employee error. He said the vehicle had different brands of belts/straps that were not compatible with each other if attempted to use together and would not create a secure hold. The plant operations director said he has since disabled and/or removed all the incompatible straps in the mini van and replaced them with all matching and compatible belts/straps to prevent the recurrence of the error. The plant operations director said he inspected the other facility vehicles to make sure they all had compatible belts made from the same manufacturer. The plant operations director said all daily inspections of the vehicles, before they transport a resident, now require the driver to test the seatbelts with force to ensure the belts stay latched when in use. The NHA said the vehicles were inspected monthly prior to 9/15/25. She said the drivers were now inspecting and recording daily inspections on the vehicles before they transport residents as part of the plan of correction. The maintenance assistant was interviewed on 11/5/25 at 4:06 p.m. The maintenance assistant said he has had ongoing training with the facility vehicle. He said he sometimes assisted with resident transports but was not usually the driver. The maintenance assistant said he learned a lot since the 9/15/25 incident and was aware of what could go wrong. He said a big part of what he learned was to go slow, make sure everything was done correctly and ask questions if he saw something wrong. He said every morning the vehicles were inspected to make sure they were fit to drive and all securement components matched and latched correctly. He said CNA #1 and the plant operations director oversaw the process. He said he felt comfortable with securing a resident and driving the mini van if needed. The NHA and the plant operations director were interviewed together on 11/5/25 at 4:35 p.m. The NHA said the facility would continue with the plan of correction to prevent resident injuries during transport. The plant operations director said the facility would continue to look at ongoing training opportunities for transport drivers.</p>		