Printed: 02/11/2025
Form Approved OMB
No. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	325118	A. Building B. Wing	10/10/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Gallup Nursing & Rehabilitation LLC	306 East Nizhoni Blvd Gallup, NM 87301

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 0550 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Honor the resident's right to a dignified existence, self-determination, communication, and to exercise his or her rights. 49196 Based on observation, record review, and interview, the facility failed to promote care with dignity and respect for 1 (R #35) of 1 (R #35) residents reviewed for residents' rights when staff closed the resident's room door against his wishes and without communicating why to the resident. This deficient practice is likely to result in residents feeling disrespected and as if they were kept in their room against their will. The findings are: A. On 10/07/24 at 1:35pm during at interview, R #35 stated the Housekeeping Manager (HM) #1 angrily slammed his door shut last week while he was listening to his music, which made him feel like the staff did not respect or care about his feelings. B. On 10/07/24 at 2:00pm, during an observation, R #35 listened to music. The volume was loud enough to be heard in the immediate hallway. Other residents in the hallway did not appear to be affected by the music. C. On 10/10/24 at 12:47pm, during an interview with HM #1, she recalled the incident in which she shut the resident's door and stated R #35's music was playing loudly while the staff had a meeting in the nearby conference room. She stated she was asked by the facility Administrator to close the resident's door. She stated she informed the resident that she would close his door. She stated she did not wait for a response from the resident, because she could tell he was agitated. D. On 10/10/24 at 1:00pm, during an interview and record review with the Administrator, she stated she was aware of the incident. The Administrator provided a written statement from HM #1, dated 10/04/24, which revealed HM #1 informed R #35's roommate rather than R #35 that she was closing the door.

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: 325118	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 10/10/2024
NAME OF PROVIDER OR SUPPLIER Gallup Nursing & Rehabilitation LLC		STREET ADDRESS, CITY, STATE, ZIP CODE 306 East Nizhoni Blvd Gallup, NM 87301	

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 0655 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Create and put into place a plan for meeting the resident's most immediate needs within 48 hours of being admitted **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 40671 Based on record review and interview, the facility failed to create a Baseline Care Plan (minimum healthcare information necessary to properly care for a resident immediately upon their admission to the facility) within 48 hours of admission for 1 (R #108) of 3 (R #15, #25 and #108) residents reviewed for Baseline Care Plans. This deficient practice could likely result in a decline in the residents' condition due to staff not being aware of the care residents' need and residents not being able to attain or maintain their highest practical level of well-being. The findings are: A. Record review of the Face Sheet for R #108 revealed an admitted [DATE] and included the following diagnoses: - Acute respiratory failure with hypoxia (when there is not enough oxygen in your blood/body tissue).- Type 2 diabetic mellitus with neuropathy (high blood sugar with nerve damage). - Hyperlipidemia (high blood fat levels).- Obstructive sleep apnea (repeated breathing interruptions during sleep). - Hypertension (high blood pressure). - Atherosclerotic heart disease (build up of fats, cholesterol and other substances in and on the artery walls). - Congestive heart failure (when your heart can't pump blood well enough to meet the body's needs). - Pneumonia due to coronavirus disease (infection in the lungs). - Asthma (condition that affects the lungs and makes breathing difficult). - Muscle wasting and atrophy (loss of muscle mass and strength). - Overactive bladder. - Difficulty in walking. - Post COVID-19 condition [any medical condition that continues for more than 3 months linked to Covid-19 (contagious respiratory infection)] . B. Record review of baseline care plan for R #108 revealed it was created on 09/30/24, which was more than 48 hours after the resident's admission. C. One 10/10/24 02:31 PM during an interview with the Administrator, she stated staff should have created the baseline care plan for R #108 within 48 hours. She verified staff did not complete a baseline care plan for R #108 until three days after the resident was admitted to the facility.

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 325118	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 10/10/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Gallup Nursing & Rehabilitation LLC	306 East Nizhoni Blvd Gallup, NM 87301

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 0658 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure services provided by the nursing facility meet professional standards of quality. 49196 Based on record review and interview, the facility failed to meet professional standards of practice for 1 (R #208) of 1 (R #208) residents reviewed for medication administration, when staff did not administer R #208's lactulose [a medication used to prevent and treat complications of hepatic encephalopathy (liver disease) by decreasing the amount of ammonia in the blood] as ordered by the medical provider. This deficient practice could likely lead to the resident having adverse (unwanted, harmful, or abnormal result) side effects or not receiving the desired therapeutic effect of the medication due to it not being administered. The findings are: A. Record review of R #208's Physician orders revealed the following: Lactulose. Give 45 milliliters (ml) by mouth three times a day for enchphalopathy with a start date of 08/30/24. B. Record review of R #208's Medication Administration Record (MAR), dated September 2024, revealed staff did not administer the lactulose midday dose to the resident due to hold/see nursing notes on 9/3/24. C. Record review of R #208's nurse progress note, dated 09/03/24, revealed the resident had three loose stools since the morning. Staff did not administer the lactulose. D. On 10/10/24 at 3:33 PM, during an interview, the DON stated staff should not have held R #208's lactulose due to loose stools. The DON stated R #208's lactulose was ordered to address encephalopathy not constipation, and the medication helped to decrease ammonia levels in the blood. The DON stated loose stools would be indicative of the medication having the desired outcome.

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 325118	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 10/10/2024
NAME OF PROVIDER OR SUPPLIER Gallup Nursing & Rehabilitation LLC		STREET ADDRESS, CITY, STATE, ZIP CODE 306 East Nizhoni Blvd Gallup, NM 87301	

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 0848 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Provide a neutral and fair arbitration process and agree to arbitrator and venue. 49196 Based on interview and record review, the facility failed to ensure their binding arbitration agreement included a provision for convenient venue (a location in which to carry out arbitration proceedings which should be agreed upon and suitable for both parties) selection. Failure to include this provision in the agreement could likely result in residents who choose to seek arbitration experiencing frustration and difficulty deterring them from exercising their rights. This deficient practice has the potential to affect 56 of the 57 facility residents who signed the binding arbitration agreement. The findings are: A. Record review of the facility's Voluntary Arbitration Agreement, undated, revealed it did not contain a provision for the selection of a convenient venue should arbitration become necessary. B. On 10/10/24 at 1:00 pm during an interview with the facility Administrator, she confirmed the binding arbitration agreement did not include a provision for a convenient venue selection and added the provision was stated in the facility's Admission Guide. C. Record review of the facility's Admission Guide revealed a provision for convenient venue selection in cases of arbitration. Further review revealed the guide did not include a signed acknowledgement that the resident received it, understood it, and that it was to be included as a part of the Voluntary Arbitration Agreement.