

| | | | |
|---|--|--|--|
| 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 01/23/2026 |
| 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 | <p>Create and put into place a plan for meeting the resident's most immediate needs within 48 hours of being admitted</p> <p>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 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 #67) of 1 (R #67) resident reviewed for baseline care plans. This deficient practice could likely result in the residents' preferences and care needs not being met. The findings are:??</p> <p>A. Record review of the facility's Care Plans- Baseline policy dated December 2016 revealed, to ensure resident's immediate care needs are met and maintained, a baseline care plan will be developed within forty-eight (48) hours of the resident's admission. B. Record review of R #67's face sheet revealed R #67 was admitted into the facility on [DATE]. C. Record review of R #67's baseline care plan revealed R #67's care plan was initiated on 01/12/26 (initiated and completed after 48 hours of admission). D. On 01/23/26 at 9:31 am, during an interview with Director of Nursing (DON), she stated it is her expectation R #67's baseline care plan should have been completed on 01/11/26. E. On 01/23/26 at 10:58 am, during an interview with the Administration (ADM), she stated it is her expectation resident's baseline care plans be completed within 48 hours.</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 |
|---|-------|-----------|

| | | | |
|--|--|--|--|
| 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 01/23/2026 |
| 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) | | |
| <p>F 0658</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Some</p> | <p>Ensure services provided by the nursing facility meet professional standards of quality.</p> <p>Based on record reviews and interviews, the facility failed to follow physician orders for 2 (R #50 and R #51) of 2 (R #50 and R #51) residents reviewed when: Facility staff failed to administer or withhold blood pressure medications as directed by blood pressure parameters (boundary or limit defining scope of particular activity or process) per R #50 and R #51's physician's order. If the facility does not follow physician orders for the management of a resident's blood pressure, then it is likely to result in the resident not maintaining optimal health outcomes as established by the medical provider. The findings are: R #50: A. Record review of R #50's physician's order dated 07/16/25 revealed, R #50's lisinopril (medication used to treat high blood pressure) medication was ordered to be held for systolic blood pressure (the pressure in the arteries when the heart beats, represented as the first (top) number in a blood pressure reading) less than 110 millimeters of mercury (mmHg). B. Record review of R #50's Medication Administration Record (MAR) dated 01/01/26 to 01/21/26, revealed R #50's lisinopril was administered on 01/05/26 with a systolic blood pressure of 105 mmHg. R #51: C. Record review of R #51's physician's orders dated 11/20/25 revealed, R #51's carvedilol (medication used to treat chronic heart failure, left ventricular dysfunction following heart attack, and high blood pressure) administration for hypertension (HTN; high blood pressure) to be held for systolic blood pressure of less than 110 mmHg or a heart rate less than 60 beats per minute. D. Record review of R #51's MAR dated 01/01/26 to 01/21/26, revealed the administration for carvedilol on 01/01/26 was documented as not administered, to see progress note. E. Record review of R #51's MAR dated 01/01/26 (for blood pressure and heart rate) revealed R #51 had a systolic blood pressure of 118 mmHg and heart rate of 70 beats per minute, which was within stated parameters of order for administration. F. Record review of R #51's progress notes dated 01/01/26 to 01/02/26 revealed the progress note did not document withholding administration of carvedilol for R #51. G. Record review of R #51's MAR dated 01/01/26 to 01/21/26, revealed R #51's evening systolic blood pressure on 01/01/26 was 118 mmHg and a heart rate of 70 beats per minute, same as the morning measurements. The evening dose of carvedilol is documented as administered to R #51. H. Record review of R #51's MAR dated 01/01/26 to 01/21/26, regarding administration of evening dose of carvedilol on 01/16/26, revealed R #51 was not administered the medication, and it was documented to see nurse's note. I. Record review of R #51's MAR vital signs (body temperature, pulse rate, respiration rate [rate of breathing], oxygen saturation [amount of oxygen in the blood], and blood pressure) dated 01/16/26, revealed R #51's systolic blood pressure was 156 mmHg and a heart rate of 60 beats per minute. J. Record review R #51's nursing notes dated 01/16/26 to 01/17/26 revealed a nursing note was not entered regarding withholding administration of carvedilol for R #51 with vital signs within parameters to administer medication. K. On 01/22/26 at 9:25 AM, during an interview with Director of Nursing (DON), she stated it is her expectation for resident's vital signs to be monitored and documented in the electronic MAR, and for medications to be administered or held according to parameters within the provider's order. The DON reviewed the MARs for R #50 and R #51, and stated her expectation is to hold lisinopril for R #50 on 01/05/26 as order states to hold for systolic blood pressure less than 110 mmHg, and R #50's systolic blood pressure was 105 mmHg. The DON stated the carvedilol for R #51 should have been administered on 01/16/26 as the systolic blood pressure and heart rate were within parameters written by provider to administer medication. The DON stated it is her expectation that nursing staff follow physician orders.</p> | | |

| | | | |
|--|---|--|--|
| 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 01/23/2026 |
| 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) | | |
| <p>F 0689</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Some</p> | <p>Ensure that a nursing home area is free from accident hazards and provides adequate supervision to prevent accidents.</p> <p>Based on observation and interview, the facility failed to maintain a safe environment and protect the residents from the potential for accidents and hazards by: Failing to ensure adhesive tape (is a strip of material with a sticky surface on one side that is used to hold, fasten, or secure items in place) applied to resident room floors remained secured and flat to the surface in Room (RM) #41, Failing to ensure a water hose connected to the ice machine remained secured within its protective case, allowing water to drip onto the floor in a hall that is accessible to all residents. This deficient practice is likely to affect all 57 residents listed on the facility census by creating a tripping and slipping hazards, which can put the residents at risk for falls and potential injury. The findings are: A. On 01/21/26 at 10:31 a.m., during an observation of RM #41, multiple strips of adhesive tape were applied directly on the bedroom floor near the bedside area. Several strips of tape appeared worn, partially detached, and curling upward at the edges. Dark adhesive residue remained on the floor where tape had deteriorated (worn out, damaged, or in worse condition than before, often from age, use, or lack of maintenance) or been removed, creating uneven and sticky surface areas which were a potential hazard for the room occupants. B. On 01/21/26 at 11:00 a.m., during an observation of the hallway leading to the dining room, a hose was connected to a wall-mounted water source next to the ice machine and it was actively dripping water onto the floor, creating a small puddle. The hose was intended to be secured within a clear plastic protective case; however, the clear plastic case did not securely hold the hose in place. C. On 01/23/26 at 10:30 a.m., during an interview with the Maintenance Supervisor (MS), he stated it was his expectation that tape applied to floors should be flat to the ground to prevent a tripping hazard. He further stated the water hose nozzle should be secured inside the clear plastic case to prevent dripping water onto the floor, which could cause a resident to fall. D. On 01/23/26 at 10:31 a.m., during an interview with the Administrator (ADM), she stated the hose should be always secured to prevent water from dripping onto the floor, as this could cause a fall. She also stated tape placed on the floor should remain flat with the surface to prevent residents from tripping or falling.</p> | | |

| | | | |
|--|---|--|--|
| 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 01/23/2026 |
| 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) | | |
| <p>F 0842</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p> | <p>Safeguard resident-identifiable information and/or maintain medical records on each resident that are in accordance with accepted professional standards.</p> <p>Based on a record review and interviews, the facility failed to ensure medical records were complete for 1 (R #51) of 1 (R #51) resident reviewed when staff failed to: Document accurately and completely when R #51 was not administered medication per physician's orders. This deficient practice is likely to result in staff not having the information they need to provide competent, comprehensive care and services to residents. The findings are: A. Record review of R #51's physician's orders dated 11/20/25 revealed, R #51's carvedilol (medication used to treat chronic heart failure, left ventricular dysfunction following heart attack, and high blood pressure) administration for hypertension (HTN; high blood pressure) to be held for systolic blood pressure (the pressure in the arteries when the heart beats, represented as the first (top) number in a blood pressure reading) of less than 110 mmHg or a heart rate less than 60 beats per minute. B. Record review of R #51's Medication Administration Record (MAR) dated 01/01/26 to 01/21/26 revealed the administration for carvedilol on 01/01/26 was documented as not administered, to see progress note. C. Record review of R #51's MAR dated 01/01/26 (for blood pressure and heart rate) revealed R #51 had a systolic blood pressure of 118 mmHg and heart rate of 70 beats per minute, which was within stated parameters of order for administration. D. Record review of R #51's progress notes dated 01/01/26 to 01/02/26 revealed no progress note documented withholding administration of carvedilol for R #51. E. Record review of R #51's MAR dated 01/01/26 to 01/21/26, revealed R #51's evening systolic blood pressure on 01/01/26 was 118 mmHg and a heart rate of 70 beats per minute, same as the morning measurements. The evening dose of carvedilol is documented as administered to R #51. F. Record review of R #51's MAR dated 01/01/26 to 01/21/26 revealed the evening dose of carvedilol on 01/16/25 was not administered to R #51, and it was documented as see nurses note. G. Record review of R #51's MAR vital signs (body temperature, pulse rate, respiration rate [rate of breathing], oxygen saturation [amount of oxygen in the blood], and blood pressure) dated 01/16/26, revealed R #51's systolic blood pressure was 156 mmHg and a heart rate of 60 beats per minute. H. Record review R #51's nursing notes dated 01/16/26 to 01/17/26 revealed a nursing note was not entered regarding withholding administration of carvedilol for R #51 with R #51's vital signs being within parameters to administer the medication. I. On 01/22/26 at 9:45 AM, during an interview with Director of Nursing (DON), she stated it is her expectation if a nurse is entering a medication as held and to see nurse's note or progress note, then a nurse's note or progress note should be documented stating the reasoning for holding medication. The DON confirmed R #51's medical record, regarding medication administration, was not accurate and should have been.</p> | | |

| | | | |
|--|---|--|--|
| 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 01/23/2026 |
| 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) | | |
| <p>F 0880</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p> | <p>Provide and implement an infection prevention and control program.</p> <p>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, record review, and interviews, the facility failed to maintain an infection prevention and control program designed to provide a safe and sanitary environment to prevent the development and transmission of communicable diseases and infections for 1 (R #34) of 1 (R #34) resident reviewed for infection control when: The facility did not ensure R #34's urinary catheter (a thin, sterile tube inserted into the bladder to drain urine) drainage bag had a privacy bag (bag that covers urination drainage bag) present. The facility did not ensure R #34's urinary catheter tubing (is the flexible tube that carries urine from the catheter (inside the bladder) to the drainage bag outside the body) remained off the floor to prevent contamination. These deficient practices are likely to result in repeated and ongoing exposure of residents to increased risk of infection, cross-contamination, and injury. The findings are: A. Record review of the facility's Catheter Care Procedure (steps to maintain the catheter and drainage system), last revised June 2020, revealed the accepted procedure was to secure catheter tubing to keep the drainage bag below the level of the patient's bladder and off the floor. Policy revealed privacy bags will be placed over drainage bags when resident is out of bed. B. Record review of R #34's Face Sheet, revealed R #34 was originally admitted to the facility on [DATE] with diagnoses of Dementia (a group of conditions characterized by impairment of at least two brain functions, such as memory loss and judgment), and Bladder?neck?obstruction?(bladder?neck?becomes?narrowed?or?blocked,?leading?to?difficulty?urinating). C. Record review of R #34's minimum data set (MDS, which was part of the federally mandated process for clinical assessment of all residents in nursing homes) completed on 10/20/25, indicated R #34 had a brief interview for mental status (BIMS; screening for cognitive impairment) score of 6 (00-07 is severe impairment). D. Record review of R #34's physician orders dated 08/15/25 revealed R#34 required an Indwelling Foley catheter (soft tube placed into the bladder that stays in place to continuously drain urine into a collection bag) PRN (as needed) for chronic urinary retention (bladder does not empty completely). E. On 01/20/26 at 12:04 pm, during a dining room lunch observation, R #34's catheter bag did not have a privacy bag present while R #34 was sitting in his wheelchair. F. On 01/20/26 at 12:56 pm, during an interview with Certified Nursing Aid (CNA) #5, she stated all residents should have a privacy bag covering their urinary drainage bags. G. On 01/22/26 at 1:00 pm, during an observation of the common tv area, R #34 sat in his wheelchair with his catheter tubing touching the ground. H. On 01/22/26 at 1:25 pm, during an interview with CNA #6, she stated the last CNA forgot to attach R #34's urinary catheter bag to his chair. She stated the catheter tube for R #34 should not be dragged onto the floor, as it could cause infection. CNA #6 also stated R #34's catheter tube could become caught and pulled out of the resident, causing discomfort. I. On 01/23/26 at 10:33 pm, during an interview with Director of Nursing (DON), she stated urinary catheter tubing should not be dragged on the floor. The DON stated if the catheter tube is touching the ground, it could cause an infection. The DON also stated the urinary catheter tube could get caught on something and pull the tube out of the resident. She confirmed there should always be a privacy bag on all the residents' catheter bags when they are out of their room. J. On 01/23/26 at 10:58 am, during an interview with the Administrator (ADM), she stated resident's catheter tubing should not be dragged across the ground, as it could get snagged and pull on the resident's appendage. The ADM also stated it is her expectation urinary catheter tubing for residents would be properly secured under the residents' chair. She confirmed residents should always have a private bag to cover the resident's catheter bag.</p> | | |

| | | | |
|--|---|--|--|
| 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 01/23/2026 |
| 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) | | |
| <p>F 0921</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Some</p> | <p>Make sure that the nursing home area is safe, easy to use, clean and comfortable for residents, staff and the public.</p> <p>Based on observation and interview, the facility failed to ensure residents had a safe and functional environment for 7 (Rooms: RM's #15, 31, 33, 34, 36, 37, 43, 44) of 13 (RM's #15, 16, 17, 21, 25, 31, 33, 34, 36, 37, 43, 44, 45 and 49) rooms observed when the facility failed to: Repair walls with intact, smooth, and cleanable surfaces (scuff marks, chipped paint, uneven paint, visible putty). Repair windowsills and surrounding tiles. Repair fixtures and building components (heating vent and electrical outlet). These deficient practices are likely to expose residents to an unsafe and uncomfortable environment. The findings are:?? A. On 01/21/26 at 3:12 pm during an observation of RM #15, the windowsill closest to Bed B was unpainted and separating from the wall with a gap approximately 0.5 inches.</p> <p>B. On 01/23/26 at 9:50 am, during an observation of RM # 31, the bathroom walls had scuff marks and chipped paint.??</p> <p>C. On 01/23/26 at 9:51am, during an observation of RM #33, the windowsill closest to Bed B had a loose tile.</p> <p>D. On 01/23/26 at 9:53 am, during an observation of RM #34, the windowsill closest to Bed B had a loose tile.</p> <p>E. On 01/23/26 at 9:55 am, during an observation of RM #36, observation revealed the residents heating vent had three horizontal broken slats (vent was damaged and could not properly control the flow of warm air). Further observation revealed the bathroom had scuff marks and chipped paint on the walls.?</p> <p>F. On 01/23/26 at 9:57 am, during an observation of RM #37, observation revealed scuff marks on bathroom walls.?</p> <p>G. On 01/21/26 at 10:13 am and 11:46 am, during an observation of RM #44, observation revealed the following: The interior bathroom door had visible wood putty (soft material used to fill holes, cracks, or gaps in wood to make the surface smooth before painting or finishing) that was not painted. The bathroom door and multiple walls had uneven paint coverage. Scuffed walls were present behind Bed-B. The windowsill beside of Bed-B was separating from the wall with an approximate one-inch gap. The electrical outlet housing (protective cover or casing that surrounds an electrical outlet and holds it securely in place) behind Bed A was separated from the wall.</p> <p>H. On 01/21/26 at 10:13 am and 11:46 am, during an observation of RM #43, the windowsill near Bed-B was separating from the wall.</p> <p>I. On 01/23/26 at 9:21 am, during an interview with the Maintenance Supervisor (MS), he stated all the scuff marks should be painted evenly. The MS also stated all the windowsills should be in good</p> <p>(continued on next page)</p> | | |

| | | | |
|---|--|--|--|
| 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 01/23/2026 |
| 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) |
|---|---|
| <p>F 0921</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Some</p> | <p>repair and not separating from the wall, as it could cause a draft or a resident could hurt themselves. He stated it is his expectation the resident's rooms would all be in good repair, so they feel like they are at home.?</p> |