STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	676242	A. Building B. Wing	05/15/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Ganado Nursing and Rehabilitation Center	107 E Rogers Ganado, TX 77962

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 - Immediate jeopardy to resident health or safety 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** 50531 Based on observations, interviews, and record review, the facility failed to ensure the resident environment remained as free of accident hazards as possible and each received adequate supervision to prevent accidents for 1 of 9 residents (Resident #1) reviewed for accidents and supervision. The facility failed to supervise Resident #1 who eloped from the facility on 03/30/2025 when he exited through an unlocked sliding door at the end of hallway 200 and was found outside in the driveway. The non-compliance was identified as PNC. The Immediate Jeopardy (IJ) began on 03/30/2025 and ended on 04/28/25. The facility had corrected the non-compliance before the survey began on 05/13/2025. This deficient practice could place residents at risk of harm, serious injury, or death. The findings included: Record review of Resident #1's face sheet revealed the resident had diagnoses including unspecified Parkinsonism (a neurological condition that effect movement), Dementia (decline in cognitive abilities), Osteoarthritis (a joint disease resulting in breakdown of bone cartilage), Dystonia (movement disorder), Dysphagia (difficulty swallowing), Psychosis (a condition that causes disassociation from reality), Major Depression Disorder. Record review of Resident #1's Quarterly MDS assessment, dated 3/17/25, revealed Resident #1 had a BIMS score of 3, indicating severe cognitive impairment. Further review of MDS assessment did not indicate a history of wandering behavior. Record review of Resident #1's Care plan revealed resident had no prior history of elopement and the Care Plan was updated on 3/30/25 to reflect actual elopement and as risk for elopement with interventions of providing structured activities, distraction with diversions to include food, conversation, television, books, determine need for exercise, compliance rounds and supervision. Resident required no special supervision prior to this elopement. (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 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	Record review of Form 3613-A Self-Report Incident, dated 4/4/25, revealed facility identified and reported an elopement incident that occurred when Resident #1 eloped from the facility on 3/30/25 at 4:00 p.m. in accordance with state guidelines and completed internal investigation, in-services and monitoring. Further review revealed Resident #1 was found outside the facility near the laundry room by another resident who then brought Resident #1 to the 200 Hall door and informed staff. In an interview with the Administrator on 5/13/25 at 10:20 a.m., the Administrator stated Resident #1 was found within 10 minutes of the last time he was seen by staff on 3/30/25. The Administrator stated Resident #1 had self-propelled to his room on 200 Hall (room [ROOM NUMBER]) from common area and self-propelled out the end of the hallway door. The Administrator stated the door was normally locked and required a keypad code to enter and exit, but it was unlocked on 3/30/2025 when Resident #1 eloped from facility. The Administrator stated the facility was unable to state for certain what caused the door alarm to malfunction, but believed the keypad was affected by the weather or storm on that day. The Administrator stated the affected entry way was and remained a high traffic area as that was the entry and exit way staff used for laundry and trash barrels 24-hours a day. Observation from 5/13/25-5/15/25 between hours of 8:00 a.m. and 4:00 p.m. each day revealed all of the resident corridor hallway door alarms were in working order. During an interview with the Administrator on 5/13/25 at 10:20 a.m., The Administrator stated that all of the active staff working in the facility at the time of the incident on 3/30/25 were in-serviced on resident elopement protocol. Record review of additional in-service training revealed live elopement drills were completed for all three shifts beginning 3/30/25 and continued thru 4/25/25. Record review of the facility's staff roster revealed there were 76 active current employees and all employees received elopement protocol In-service to include Elopement prevention & response, how to monitor electric sliding keypad doors to include re-setting door lock and guidance to notify Administrator immediately if door lock is not able to be re-set and to utilize door monitor at all times until door lock is repaired, elopement protocol and Abuse & Neglect. Record review of in-service training records dated 3/30/25 revealed 24 licensed nursing staff received in-service training on 3/30/25 to include how to identify residents who were elopement risk and how to locate risk Assessment, BIMS assessment and elopement care plan in EMR (Electronic Medical Record) and complete accurately. Record review of in-service training records dated 3/30/25 revealed 27 nurse aides / certified medication aids received in-service training on 3/30/25 on how to locate and identify residents who are an elopement risk. Record review of in-service training records dated 3/30/25 revealed 24 non-licensed employees received in-service on 3/30/25 on how to identify and recognize residents who may be a risk for elopement. Record review of active employee roster dated 5/13/25 revealed all employees had received elopement protocol training. (continued on next page)

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F 0689 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	Interviews with 27 staff on 5/13/25 from 10:00 a.m. to 4:07 p.m. revealed the 27 staff (Administrator, DON, Activity Director, BOM, Medical Records, HR Director, FSS, Dietary I, Dietary J, Dietary K, Dietary L, Housekeeper M, Floor Maintenance N, Housekeeper O, Laundry Aide P, CNA Q, CNA R, CNA S, CNA T, CNA U, CNA V, Hospitality Aide W, CNA X, Director of Rehab, COTA AA, PTA, BB, and OT CC) revealed they had received in-service trainings for elopement protocols, and staff were able to verbalize an understanding of the facility's elopement protocols. Record review of door monitoring dated 4/1/25-4/28/25 revealed all corridor doors, front door and dining room doors were checked every 15 minutes for security. Record review of elopement monitoring of Resident #1 was completed 3/31/25-4/28/25 with no attempts at elopement. Record review of elopement assessments were completed 5x/week for 4 weeks for all residents at risk for elopement. Record review of the facility Post Elopement Drill / Actual Elopement Guide revealed facility would verify elopement, notify staff and family, and complete post event documentation for elopement protocol. A request was made for a Policy for Elopement on 5/15/25, not received prior to exit.