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	11/15/2024

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 0578 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Honor the resident's right to request, refuse, and/or discontinue treatment, to participate in or refuse to participate in experimental research, and to formulate an advance directive. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 36232 Based on observation, interview and record review, the facility failed to ensure residents' right to formulate an advance directive for 1 of 14 residents (Resident #30) reviewed for advanced directives, in that: The facility failed to ensure Resident #40's Out-of-Hospital Do Not Resuscitate (OOH DNR) was signed by two witnesses, which made the document invalid. This failure could place residents at risk of having their end of life wishes dishonored, and of having CPR performed against their wishes. The findings included: Record review of Resident #30's face sheet, dated [DATE] revealed a [AGE] year-old female admitted to the facility on [DATE] with diagnoses that included traumatic subdural hemorrhage without loss of consciousness (a brain injury that occurs when blood pools under the dura mater, usually due to a head injury), chronic obstructive pulmonary disease (a common lung disease that makes it difficult to breathe), and chronic systolic (congestive) heart failure (a serious condition that occurs when the heart can't pump enough blood to the body). Further review of Resident #30's face sheet revealed the resident was identified as DNR status. Record review of Resident #30's 5-day scheduled assessment MDS assessment, dated [DATE], revealed the resident had a BIMS of 8, indicating moderately impaired cognition. Record review of Resident #30's comprehensive care plan, updated [DATE] revealed the resident was DNR status with interventions which included in absence of b/p, pulse, and respiration, CPR will not be initiated. Record review of Resident #30's Order Summary Report, dated [DATE], revealed the following: - DNR (Do Not Resuscitate), with an order date of [DATE] and no end date. Record review of Resident #30's OOH DNR, dated [DATE], revealed it was signed by Resident #30 and the resident's physician on that date. The area for two witnesses was blank. (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 0578 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	During an interview on [DATE] at 12:30 PM, the Regional Compliance RN stated Resident #30's OOH-DNR form was missing two signatures, rendering the form invalid. This meant the resident would receive CPR if she went into cardiac arrest. During an interview on [DATE] at 12:55 PM, the DON stated there were no witness signatures on Resident #30's OOH-DNR form, which made the form invalid. The consequence of this failure was in the event the resident goes into cardiac arrest, she would be administered CPR, which would be against her wishes. Record review of the facility policy EL ,d+[DATE].0 Do Not Resuscitate Order, revised [DATE], revealed: Procedure: 1. Any resident may initiate an Out of Hospital DNR Order. The resident's attending physician will document the presence of the terminal condition in the resident's permanent record. 2. If the resident is capable of providing informed consent for the order, he/she will sign and date the DNR order on the front of the official DNR form .5. In all cases the form must be signed and dated by two witnesses.

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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0755 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide pharmaceutical services to meet the needs of each resident and employ or obtain the services of a licensed pharmacist. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 33866 Based on observation, interview, and record review, the facility failed to ensure pharmaceutical services (including procedures that assure the accurate acquiring, receiving, dispensing, and administering of all drugs and biologicals) to meet the needs of each resident for 1 of 1 residents (Resident #37) reviewed for pharmacy services, in that: The Narcotics refrigerator in the main medication storage room, contained an opened and expired medication, Lorazepam for Resident #37. This failure could affect residents whose medications were stored in the medication storage room and place residents at risk of receiving expired medications. The findings were: Observation on 11/13/2024 at 4:17 p.m. of the facility medication storage room with the ADON present, revealed one expired medication, Lorazepam 2 mg/ml for Resident #37, found in the locked Narcotics refrigerator. The Pharmacy Label on the outside of the box read, discard 3/12/2024. The expiration date on the bottle itself was, 31 [DATE]. During an interview with the ADON on 11/13/2024 at 4:20 p.m., the ADON stated Resident #37's Lorazepam was expired and should have been discarded by the pharmacy expiration date on the label of 3/12/2024. The ADON stated that expired or discontinued medications should be removed from medication carts or storage room by each respective Nurse or Medication Aide as they conduct their medication cart checks, and that the Supply Nurse and DON, should check and dispose of any expired medications in the medication storage room during re-supply. The ADON stated that for expired controlled medications like the Lorazepam, they should be removed and placed in the locked storage inside the DON's office until the Pharmacist comes and conducts expired medication disposal. The ADON stated that keeping the expired Lorazepam stored with current medications could increase the risk of an expired medication being given, since Resident #37 was still in the facility, and noted that medication that was expired might be less effective. Record review of the Pharmacist's Monthly Medication Review for October 2024, included a Medication Cart Audit dated 9/17/2024 which revealed, Medications that have been discontinued or meds for patients that have discharged - They should be pulled from the carts/med room same day and 3. I recommend pulling expiration dates 2-3 months in advance to avoid expired administration. Record review of facility policy titled Storage of Controlled Substance undated but is part of the facility Pharmacy Policy & Procedure Manual 2003, revealed, Drugs shall not be kept on hand after the expiration date on the label, and no contaminated or deteriorated drugs shall be available.

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F 0761 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Ensure drugs and biologicals used in the facility are labeled in accordance with currently accepted professional principles; and all drugs and biologicals must be stored in locked compartments, separately locked, compartments for controlled drugs. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 33866 Based on observation, interview and record review, the facility failed to ensure all drugs and biologicals were stored in locked compartments and labeled in accordance with currently accepted professional principles reviewed for medications stored in 1 of 1 narcotics refrigerator in main medication room, and for 1 of 2 medication carts (Hall 200 Medication Cart) reviewed for storage, in that: 1. During medication administration for Resident #34, MA- A left Hall 200 Medication cart unlocked outside the resident's room, out of sight of MA-A. 2. During medication administration for Resident #20, MA-B left 8 blister packages of medication unattended and unsecured on top of the 200 Hall medication cart. These failures could place residents at risk for misappropriation of property and could place residents at risk for accidents, hazards and not receiving therapeutic effects. 1. Observation on [DATE] at 7:56 a.m. revealed MA-A entering Resident #34's room carrying a wrist blood pressure cuff and shutting the curtains to doorway behind her. While she was inside the resident's room checking Resident #34's blood pressure, the medication cart was left unlocked outside the room and out of sight of MA-A. Inside the unlocked cart were medication blister packs, bottles and vials of medications for the residents on Hall 200. During an interview with MA-A on [DATE] at 8:22 a.m., MA-A stated the medication cart was left unlocked while she was administering medications to Resident #34 inside the resident's room and out of view of the medication cart. MA-A stated she knew she was supposed to keep the medication cart locked when she was away from the cart but had forgotten to lock it. She stated that leaving the cart unlocked could result in medications being accessed by other residents or staff. During an interview on [DATE] at 11:10 a.m., the RCN stated that the medication carts need to be kept locked at all times when not being directly accessed by Nurse or Medication Aide. Record review of facility policy titled Medication Administration Procedures undated, revealed under #8. After the medication administration process is completed, the medication cart must be completely locked or otherwise secured, and included in #5 During the medication administration process the unlocked side of the cart must always be in full view of the nurse. 2. Observation on [DATE] at 8:39 a.m., revealed MA-B prepared Resident #20's medications by popping out his medications from blister packs into a medication cup, then leaving the medication blister packs on top of the medication cart, locked the medication cart, and entered Resident #20's room carrying the medication cup and water. While MA-B was inside Resident #20's room administering his medications, the medication blister packs for the following medications: Buspirone 10 mg, Rytary 48XXX,d+[DATE] mg, Lasix 20 mg, Losartan 50 mg, Venlafaxine 75 mg and Venlafaxine 150 mg, Tizanidine 2 mg and Potassium Chloride ER 20 meq were left unsecured and unsupervised on top of the medication cart that was located outside his room and out of sight from MA-B. (continued on next page)

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F 0761 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	During an interview with MA-B on [DATE] at 8:48 a.m. MA-B stated she knew she was supposed to keep the medications locked inside the cart but stated she got nervous and forgot to lock them back up inside the cart when she went inside Resident #20's room to give him his medications. MA-B stated that leaving medications out on top of the cart unsecured and unattended could result in someone stealing the medications or accidentally taking them. During an interview on [DATE] at 9:00 a.m., the RCN stated medications should always be secured inside the locked medication cart and stated that the Medication Aide had been trained in medication administration and keeping medications locked but was just nervous and off her normal routine while being monitored by the Surveyor. Record review of the Pharmacist's Monthly Medication Review for [DATE], included a Medication Cart Audit dated [DATE] which revealed, Medications that have been discontinued or meds for patients that have discharged - They should be pulled from the carts/med room same day and 3. I recommend pulling expiration dates ,d+[DATE] months in advance to avoid expired administration. Record review of facility policy titled Storage of Controlled Substance undated but is part of the facility Pharmacy Policy & Procedure Manual 2003, revealed, Drugs shall not be kept on hand after the expiration date on the label, and no contaminated or deteriorated drugs shall be available.

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F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide and implement an infection prevention and control program. 33866 Based on observation, interview, and record review, the facility failed to maintain an Infection prevention and control program designed to provide a safe, sanitary, and comfortable environment and to help prevent the development and transmission of communicable disease and infection for 1 of 7 residents (Resident #24) reviewed for infection control, in that: MA A did not sanitize the blood pressure cuffs (wrist and manual) and stethoscope between use with different residents. This deficient practice could place residents at-risk for infection due to improper care practices. The findings include: During an observation on 11/13/2024 at 7:56 a.m. MA A was observed to take the blood pressure for Resident #34 using a wrist blood pressure (B/P) cuff at first, and then after repeated error messages, switched to using the manual B/P cuff with stethoscope to assess Resident #34's blood pressure. MA-A then placed the wrist cuff back on the medication cart and the manual blood pressure (B/P) cuff inside the medication cart along with stethoscope and proceeded with medication administration to Resident #34. Then without sanitizing either the wrist or manual B/P cuff and stethoscope proceeded to Resident #24 to take his blood pressure using both the same wrist and manual B/P cuffs and stethoscope. During an interview with MA A on 11/13/2024 at 8:22 a.m., MA A stated she had taken blood pressures on two different residents using the same wrist and manual B/P cuffs and stethoscope and stated she did not sanitize the cuffs or stethoscope between the residents. She stated she just forgot, but knew she was supposed to sanitize the cuffs in between uses with different residents as not sanitizing could be a risk for infection for the residents. She confirmed receiving training for infection control within the year. During an interview on 11/13/2024 at 11:10 a.m., the RCN stated the MA should have sanitized the blood pressure cuff and stethoscope in between use with the different residents to avoid cross contamination. The RCN revealed infection control training was provided to the staff annually and as needed with competency checks. Review of facility policy, titled Fundamentals of Infection Control Precautions, updated 3/2023, revealed Non-invasive resident care equipment is cleaned daily or as needed between use by the nursing assistant and Under Surveillance section Ensures that reusable equipment is appropriately cleaned, disinfected or reprocessed.

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F 0921 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Make sure that the nursing home area is safe, easy to use, clean and comfortable for residents, staff and the public. 41651 Based on observation, interview, and record review, the facility failed to provide a safe, functional, sanitary, and comfortable environment for residents, staff and the public for 1 of 3 spa/shower rooms reviewed, in that: The toilet in the spa/shower room on 200 hallway was loosely affixed to the floor and was able to be moved approximately two inches to the side. This deficient practice could place residents, staff, and the public at risk of living, working, and visiting within an environment which was unsafe and not functional. The findings were: Observation on 11/12/2024 at 11:10 a.m. revealed the toilet in the spa/shower room on 200 hallway was loosely affixed to the floor and was able to be moved approximately two inches to the side. During an interview with the Administrator on 11/12/2024 at 11:12 a.m., the Administrator confirmed the toilet in the spa/shower room on 200 hallway was loosely affixed to the floor and was able to be moved approximately two inches to the side. The Administrator further confirmed that anyone who attempted to utilize the toilet could possibly fall and sustain an injury. The Administrator directed staff to close the spa/shower room until the toilet was repaired. Record review of the facility's Preventive Maintenance Policy dated 2003 revealed, Preventative maintenance is an undeniably critical component to any maintenance strategy .It is key to lowering maintenance costs, reducing equipment downtime improving asset lifespan, efficiency and increasing environmental safety .Maintenance employee will take the necessary precautions and actions to reduce equipment failures from occurring before they happen. For example, performing regular business and equipment inspections, cleaning and lubricating essential equipment, tidying the facility grounds .