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	12/18/2024

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 0609 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Timely report suspected abuse, neglect, or theft and report the results of the investigation to proper authorities. Based on record review and interview, the facility failed to provide facility Initiated Reports (mandatory self-initiated facility report of an incident) to the State Survey Agency (SSA) for 1 (R #1) of 3 (R #'s 1, 2 and 3) residents reviewed for incidents when staff failed to report an unwitnessed fall with an injury for R #1. The findings are: A. Record review of R #1's nursing progress notes dated 09/13/24 revealed that R #1 was found on the floor in his room laying on his stomach at the foot of the bed about 1 foot from floor safety mat. Upon assessment, resident was noted to have a cut about 4 centimeters long over his right eye. The wound was cleansed with normal saline, antibacterial ointment (topical medication used to prevent infections) was applied, and the wound was covered with a bandage which was used to reinforce and keep the resident from touching it. B. Record review of R #1's nursing progress note, also dated 09/15/24, revealed that R #1 had a change in condition of altered mental status. This nursing note also revealed that R #1 was alert and oriented x1 (times one), began mumbling words, slowly responding to his name. Send to emergency room (ER) for CT scan (computed topography - medical imaging technique used to obtain detailed internal images of the body). C. Record review of facility's Incident Report Log, received on 12/16/24 from the Administrator (ADM), revealed that no incident for R #1 having an unwitnessed fall with an injury had been reported. D. Record review of facility Response to Falls policy revealed: Post-Fall Assessment and Monitoring - a. Following each resident fall, the Licensed Nurse will complete an incident report and perform a post-fall assessment and investigation. b. The Licensed Nurse will also complete the Neurological Flow Sheet for any un-witnessed fall, or witnessed fall with known head injury for 72 hours following the fall. c. Nursing staff, with the attending physician's guidance, will follow up on any fall associated with an injury until the resident is stable, and delayed complications like that of a late fracture or a subdural hematoma (bleeding of or near the brain) have been ruled out or resolved. i.) Delayed complications such as late fractures and major bruising may occur hours or several days after a fall. ii.) Signs of subdural hematoma or other intracranial bleeding (bleeding in the brain) can occur up to several weeks after a fall. (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 0609 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	E. On 12/17/24 at 12:09 am during an interview, the Administrator (ADM) verified that the facility had not filed an incident report for R #1 for the unwitnessed fall with injury that occurred on 09/13/24 and further stated that she [Administrator] is the one responsible for filing the incident reports with the SSA but that she can only report an incident if she is made aware of it. She stated that the unwitnessed fall with injury had not been reported to her and that it should have been reported by the nurse. She stated that the nurse who wrote the progress note regarding the fall was an agency nurse who is no longer employed with the facility.

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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 0684 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	Provide appropriate treatment and care according to orders, resident's preferences and goals. Based on record review and interview, the facility failed to ensure residents received treatment and care in accordance with professional standards of practice for 1 (R #1) of 3 (R #'s 1, 2 and 3) residents when they failed to properly assess a resident following an unwitnessed fall that resulted in injury. If the facility fails to properly assess residents who have an unwitnessed fall with an injury, then the residents may experience unidentified life-threatening conditions such as a brain bleed. This deficient practice likely contributed to the hospitalization and passing of R #1. The findings are: A. Record review of Face Sheet for R #1 revealed an admission date of 7/13/24 and a discharge date of 09/21/24 and included the following diagnoses: - Lack of Coordination - Muscle Wasting and Atrophy (wasting away) - Depression (mood disorder that causes a persistent feeling of sadness and loss of interest) - Generalized Muscle Weakness (muscle weakness that affects the whole body) - Dysphagia (difficulty swallowing) - Difficulty in Walking - Parkinson's Disease (a brain disorder that affects movement such as shaking, stiffness, and difficulty with balance and coordination) - Hypertension (high blood pressure) B. Record review of R #1's nursing progress note, dated 07/14/24, revealed he was admitted to the facility for skilled nursing services related to frequent falls. C. Record review of R #1's care plan initiated on 07/15/24 revealed resident was at risk for falls related to history of multiple falls, poor safety awareness, poor vision, Parkinson's, hypotentsion, new environment, deficit to his left side, decline in condition and needs assistance with ADLs (activities of daily living). D. Record review of R #1's nursing progress note, also dated 07/14/24, revealed that R #1 was found laying on the floor between the two beds. E. Record review of R #1's nursing progress note, dated 07/15/24, revealed that R #1 is a very high fall risk, having had one fall. Daughter stated he has very poor safety awareness and had multiple falls in the community with injury. Staff to continue to monitor. F. Record review of R #1's nursing progress note, dated 09/03/24, revealed that R #1 has poor safety awareness due to dementia and will attempt self-transfer/ambulation without assistance. Therapy informed of fall and care plan updated. Progress note did not provide any information on a recent fall. (continued on next page)

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F 0684 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	G. Record review of R #1's nursing progress note, dated 09/10/24, revealed that R #1 is impulsive and requires assistance with Activities of Daily Living (ADLs). Resident is not safely able to transfer or ambulate independently. Therapy notified of fall and care plan updated. Progress note did not provide any information on a recent fall. H. Record review of R #1's nursing progress note, dated 09/13/24 at 3:50 am, revealed that R #1 was found on the floor in his room laying on his stomach at the foot of the bed about one foot from the floor safety mat. Upon assessment resident noted to have a cut about 4 centimeters (cm - unit of measure) long over his right eye and that neuro checks (an evaluation used to assess the mental status of individuals with head injuries) were initiated. I. Record review of R #1's nursing progress note, dated 09/14/24, revealed the following vital signs were taken on 09/13/24: Blood pressure (BP) - 93/52 Temperature - 98.0 Pulse - 70, regular Respirations - 18 Oxygen (O2) - 97 percent (%) on room air (not using supplemental oxygen) J. Record review of R #1's nursing progress note, dated 09/15/24, revealed the following vital signs were taken on 09/14/24: Blood pressure (BP) - 104/44 Temperature - 97.9 Pulse - 64, regular Respirations - 24 Oxygen (O2) - 95% K. Record review of R #1's nursing progress note, also dated 09/15/24, revealed that R #1 had a change in condition of altered mental status and included the following vital signs: Blood pressure (BP) - 124/61 Temperature - 97.5 Pulse - 73, regular Respirations - 20 Oxygen (O2) - 93% (continued on next page)

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F 0684 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	This nursing note also revealed that R #1 was alert and oriented x1 (times one), began mumbling words, slowly responding to his name. Send to emergency room (ER) for CT scan (computed topography - medical imaging technique used to obtain detailed internal images of the body). L. Record review of R #1's Neuro Evaluations revealed that no neuro evaluations were completed or documented following R #1's unwitnessed fall on 09/13/24. M. Record review of R #1's Fall Risk Evaluations revealed no fall risk evaluation was completed following R #1's unwitnessed fall on 09/13/24. N. Record review of facility reportable incidents revealed no documentation of R #1's unwitnessed fall with injury on 09/13/24. O. Record review of facility Response to Falls policy revealed: Post-Fall Assessment and Monitoring - a. Following each resident fall, the Licensed Nurse will complete an incident report and perform a post-fall assessment and investigation. b. The Licensed Nurse will also complete the Neurological Flow Sheet for any un-witnessed fall, or witnessed fall with known head injury for 72 hours following the fall. c. Nursing staff, with the attending physician's guidance, will follow up on any fall associated with an injury until the resident is stable, and delayed complications like that of a late fracture or a subdural hematoma (bleeding of or near the brain) have been ruled out or resolved. i.) Delayed complications such as late fractures and major bruising may occur hours or several days after a fall. ii.) Signs of subdural hematoma or other intracranial bleeding (bleeding in the brain) can occur up to several weeks after a fall. P. Record review of R #1's hospital documentation dated 09/15/24, revealed that patient presented with altered mental status; his baseline is awake and alert x 3 (times three), however here he is awake and alert x 0; per nursing, this patient had a couple of falls over the last few days with 1 possibly as recently as last night; he is not moving his left lower extremity; he has bruising around the right orbital rim and around the right eye; the degree at onset was severe, the degree at present is severe. Patient was intubated (the process of inserting a tube into the mouth or nose and then into the airway). Patient has periorbital ecchymosis (dark purple or blue bruises under the eyes); was found to have a large left temporal lobe bleed (sudden bleeding in the brain); patient is greatly deconditioned (decline in physical fitness due to inactivity) and only exhibits limited movement in each of the limbs. I think that this bleed is probably the result of one of his falls. Patient was accepted by the triage physician at [name of hospital], he is now intubated, sedated (to make calm) on fentanyl (pain medication) and precedex (sedating medication used for patients who are intubated); awaiting transfer, flight team on their way. Q. Record review of R #1's radiology report dated 09/15/24 for CT scan of head, revealed the following: 1. Temporal parenchymal hemorrhage (bleeding in the brain) - this could represent an evolving hemorrhagic infarction (stroke) or a direct contusion (bruise) to the brain parenchyma (brain tissue). (continued on next page)

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F 0684 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	2. Subdural (area between the brain and the skull) and subarachnoid (area between the brain and the tissue covering the grain) hemorrhage (blood loss). 3. Small intraventricular hemorrhage (type of bleeding that occurs within the ventricles of the brain). R. Record review of R #1's nursing progress note, dated 09/16/24, revealed that R #1 was admitted to [name of hospital]. S. Record review of R #1's care plan initiated 09/19/24 revealed At risk for abnormal bleeding or hemorrhage due to antiplatelet (medications that prevent blood clots from forming) use. T. On 12/17/24 at 11:01 am during an interview with the Director of Nursing (DON) and the Administrator (ADM), the DON stated that she would expect there to be neuro checks done for 72 hours and that a resident would only be sent out if there was an identified change in condition. DON further stated that R #1 had falls in July and then he was doing good with not having any and then it changed and he started having falls and the falls got closer together. She stated that she would have expected there to be neuro checks and verified that there were none done for R #1 following his unwitnessed fall on 09/13/24. DON stated that rounds are done each shift but that they are not documented. U. On 12/17/24 at 12:32 pm during an interview, Assistant Director of Nursing (ADON) stated that when she began her day shift on 09/13/24, the night shift nurse relayed the information about R #1 being found laying on the floor and that he had a laceration to the right side of his forehead and that the night nurse had began neurological checks for him, however there were none documented. ADON further stated that she was the only nurse on the floor on 09/15/24 because the other nurse had called out of work and that she remembers that R #1 was taking his medications and was verbally responding to her and was able to stand for her on 09/13/24 and 09/14/24, but that on 09/15/24 she noticed that he was choking on his medications (medications were administered crushed and with thickened liquids) and that he was also having weakness and was not responding to her. The ADON confirmed that the resident was sent out to the hospital. V. Record review of the complaint intake received by the State Survey Agency on 11/20/24 identified that R #1 passed away in the hospital. Based upon the evidence, immediate jeopardy was identified. The facility Administrator was notified on 12/17/24 at 2:43 pm. The facility took corrective action by providing an acceptable Plan of Removal (POR) on 12/18/24 at 12:11 pm. Implementation of the POR was verified onsite on 12/18/24 by conducting record reviews and staff interviews. Plan of removal: Resident was discharged to the hospital. Resident had an unwitnessed fall and neurological checks were incomplete. Residents who reside at the facility that have experienced an unwitnessed fall or a fall in which the resident hit their head have the potential to be affected by this alleged deficient practice. (continued on next page)

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F 0684 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	Review of the last seventy-two hours of fall occurrence were reviewed to validate, if any resident experienced unwitnessed fall and that neuro checks and vital signs were completed as scheduled, any issues identified to be addressed upon discovery. This audit was completed by the Director of Nursing by 12/17/24. Neurological Checks and Obtaining/Completing Vital Signs re-education for Licensed Nurses were initiated on 12/17/24 by Director of Nursing. If omissions noted within neurological checks and/or vital signs, Director of Nursing/designee to conduct a neurological assessment of the resident to ensure no neurological changes are noted, any issues identified to be addressed upon discovery. Director of Nursing and/or designee was re-educated by the Clinical Consultant on 12/17/24 on the following: - Fall documentation related to neurological checks and vital sign obtaining/completion as scheduled. Director of Nursing and/or designee will re-educate Licensed Nurses including agency personnel on the following: - Fall documentation related to neurological checks and vital sign obtaining/completion as scheduled. The above education will be completed by the Director of Nursing/designee, this education will be initiated on 12/17/24, all other licensed nurses will be educated prior to their next scheduled shift. This information will be presented in new hire orientation. The above audits to be completed daily for two weeks, then three times a week for two weeks, then twice a week for two weeks, then weekly for four weeks, then bi-monthly for additional two weeks, then randomly thereafter, any concerns identified to be addressed upon discovery. Facility Administrator will be responsible for the overall implementation and validation of this plan. Facility Medical Director will be informed of this plan and given progress updates. The Medical Director was notified of the Immediate Jeopardy on 12/17/24.