STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 325036	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 02/09/2026
NAME OF PROVIDER OR SUPPLIER: Las Palomas Center		STREET ADDRESS, CITY, STATE, ZIP CODE: 8100 Palomas Avenue NE Albuquerque, NM 87109	

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 0627 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure the transfer/discharge meets the resident's needs/preferences and that the resident is prepared for a safe transfer/discharge. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on record review and interviews, the facility failed to appropriately discharge 1 (R #1) of 1 (R #1) resident when the facility failed to re-admit R #1 from the hospital and ensure coordination with an appropriate receiving facility so R #1's needs could be met after discharge from the hospital. This deficient practice resulted in R #1 being discharged to the hospital without a plan for her return to the facility and without appropriate coordination to ensure R #1's wellbeing and continuity of care following the hospital stay. The findings are:A. Record review of R #1's face sheet revealed R #1 was admitted into the facility on [DATE] and was discharged to the hospital on [DATE] with the following medical diagnoses (including but not limited to): 1. Cerebral infarction (occurs when blood flow to a part of the brain is obstructed). 2. Unspecified cerebrovascular disease. (various conditions that disrupt blood flow to the brain) 3. Dysphagia (difficulty swallowing) following unspecified cerebrovascular disease. 4. Generalized anxiety (a feeling of worry, nervousness or unease) disorder. 5. Dementia (loss of cognitive functioning that interferes with daily life and activities) in other diseases classified elsewhere, severe, with other behavior disturbance. 6. Age-related cognitive decline. 7. Other symptoms and signs involving appearance and behavior. 8. Major depressive disorder (a persistent feeling of sadness and loss of interest), recurrent, moderate. 9. Unspecified symptoms and signs involving cognitive functions following cerebral infarction. 10. Personal history of traumatic brain injury (brain injury that is caused by an outside force). 11. Aphasia (disorder that affects language abilities due to brain damage) following unspecified cerebrovascular disease. 12. Cognitive communication deficit.B. Record review of R #1's nursing progress notes revealed the following: 1. On 09/07/25 at 7:01am: Change in condition: Behavior symptoms. Monitor resident for signs and symptoms of aggression toward others and notify physician for any new incident. 2. On 09/07/25 at 2:05pm: Called (Name of local police department(APD) to report R #1 having homicidal ideations. 3. On 09/07/25 at 4:40 pm: R #1 was sent to hospital to be evaluated for homicide idealization against three residents. Guardian contacted.4. On 09/08/25 at 9:36 am: R #1 was placed on 1 to 1 supervision (supervision by one staff member within close proximity). Care plan reviewed and updated.5. On 09/08/25 at 5:10 pm: R #1 came back from the hospital to the facility at 3:10 pm. 6. On 09/10/25 at 4:04 pm: Mood is pleasant, no unwanted behaviors witnessed. 7. On 09/10/25 at 12:45 am: Mood is pleasant, no unwanted behaviors witnessed. 8. On 09/11/25 at 9:26 am: Change in condition: Behavioral symptoms. Send out for eval and treatment 9. On 09/11/25 at 5:49 am: R #1 was received sleeping comfortably in bed. Woke up twice to use the bathroom and went back to sleep. R #1 was accompanied to join the smoke break at 5:10 am. Nil (no) behavior seen throughout the night.10. On 09/11/25 at 1:00 am: R #1 is a threat to herself and others. Despite being on 1 to 1 supervision, R #1 continues to have verbal and physical aggression towards staff and others. R #1 care cannot safely be managed at this level of care. 11. On 09/11/25 at 9:33 am: R #1 placed on a 1 to 1 supervision. When R (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 0627 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	#1 returned from the hospital on [DATE] at approximately 3:30 pm, due to the recent escalation (when a situation gets bigger, worse or more intense) of threatening behaviors which led to her being sent out on 09/07/25, the nurses and Certified Nurse Aide (CNA)'s have provided the 1 to 1 supervision since her return. R #1 was evaluated by two Psych providers since R #1's return, both agreed that a 1 on 1 supervision was appropriate, and new medication orders were also placed. At approximately 8:30 am on 09/11/25, R #1 approached the Administrator, Director of Nursing (DON) and supervising staff member and expressed frustration with having 1 to 1 supervision and began demonstrating aggressive behavior and cussing at the Administrator. R #1 proceeded to hit the Administrator and then threw a vase of flowers at the Activities Director hitting her. Due to R #1 being a present danger to herself or others, 911 was activated. 1 to 1 remained in place while waiting for APD/EMS to arrive. 12. On 09/11/25 at 11:38 am: R #1 was discharged and exited the facility with EMS (emergency medical service) and APD to local hospital. D. Record review of the facility's change in condition form for R #1 revealed the following: 1. On 09/07/25 at 7:01 am: Resident still verbalizing anger and frustration toward other. Resident became verbally abuse toward other resident in the dining room at breakfast time. She did not get physical. One on one care per protocol initiated. Message left to the guardian at 10:50 am. 2. On 09/11/25 at 9:26 am: police notified of incident (aggressive behaviors),1 to 1 supervision continues to be at resident's side. Increased aggression noted verbal and physical behaviors noted. R #1 threw a vase with flowers at Activity director and slapped the administrator. Guardian notified at 9am.E. Record review of R #1's care plan dated 09/05/25 revealed the following: 1. R #1 has the potential to demonstrate verbal and/or physical behaviors. 2. R #1 is at risk for elopement (to leave secretly). 3. R #1 exhibits and has the potential to exhibit physical behavior. Interventions: Monitor medications and body language for aggressive intent of verbal behaviors. Evaluate the nature and circumstances (i.e., triggers) of the verbal aggression with resident/patient and/or resident representative. Evaluate need/provide for Psych/Behavioral Health consultation. Remove [name of R #1] from the environment if needed. Gently guide her from the environment while speaking in a calm, reassuring voice. Allow time for expression of feelings; provide empathy, encouragement, and reassurance. Remind [Name of R #1] that she should ignore the other resident and seek assistance from staff if approached by another resident.F. On 01/14/26 at 11:12am during an interview with the guardian, she stated R #1 was discharged to the hospital on a Thursday (09/11/25) and she was abandoned by the facility because they would not re-admit R #1 once she was ready for discharge from the hospital on [DATE]. R #1 has documented behaviors since her admission to the facility. R #1 has been sent to the hospital for evaluation and treatment in the past. The facility dumped R #1 in the hospital with no proper discharge plan and that is unsafe. R #1 stayed in the emergency room holding area while the guardian and hospital case managers find her a safe place to live. R #1 has nowhere to go, and she showed no aggressive behavior in the hospital and was denied re-admission to the facility. The guardian confirmed R #1 cannot take care of herself and would be in danger if she was discharged from the hospital to the streets. R #1's guardian also confirmed R #1 was eventually discharged from the hospital to an out-of-town assisted living facility.G. On 01/15/26 at 1:33pm during an interview with the social services director (SSD), she stated R #1 expressed frustration and confronted the administrator on 09/11/25 regarding the 1 to 1 supervision that was placed since 09/07/25. R #1 then hit the administrator and threw a vase to the activity director. This prompted the facility to call the police and R #1 was taken to the hospital for evaluation and treatment. SSD believed the facility did everything they could to de-escalate the situation and follow protocol (communicate with R #1 calmly, remove from situation, demonstrate understanding) for this situation. SSD stated that she (continued on next page)

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