STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	325062	A. Building B. Wing	12/05/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Paloma Springs Healthcare LLC	1400 North Silver Street T OR C, NM 87901

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. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on record review and interview, the facility failed to report an injury of unknown origin to the State Agency (SA) for 1 (R #1) of 3 (R #1, R #2 and R #3) residents sampled for neglect. If the facility fails to report allegations of possible neglect to the SA, then the SA is unable to ensure residents are free from neglect and have a safe home environment. The findings are:A. Record review of the facility's incident report for R #1 dated 09/28/25 at 6:30 AM revealed the following: 1. Incident documented as other. 2. Nursing description of incident: R #1 was found in bed with blood on her face, her bed, the floor and in the trashcan. 3. Resident description of incident: R #1 stated she was not sure what happened. When asked if she fell resident stated I'm not sure, I don't remember what happened. I don't know if I fell. 4. Immediate action taken by staff: R #1 was assessed by nursing staff, provider was notified of the incident and R #1 was sent to the emergency room for further evaluation. B. On 12/04/25 at 2:53 PM, during an interview with LPN #1 revealed the following: 1. LPN #1 stated she assessed R #1 at approximately 6:20 AM on 09/28/25. 2. R #1 had a knot (bump) on her forehead, blood on her face, and abrasions (scrapes) to both her elbows and her knees. LPN #1 stated she could not tell where the blood had come from. 3. LPN #1 stated R #1 said she could not remember what happened. 4. LPN #1 contacted the on-call provider, and R #1 was sent out to the emergency room for further evaluation 09/28/25 at 6:45 AM. 5. R #1 returned to the facility on [DATE] at approximately 12:00 PM. 6. R #1 was diagnosed with a contusion (bruising that does not break the skin and is characterized by tenderness and swelling in the affected area). C. On 12/05/25 at 12:20 PM, during an interview with the administrator, the following was revealed: 1. R #1's incident was listed as other because initially the facility staff did not know how R #1 was injured. 2. R #1's incident was not reported to the SA. 3. R #1's incident was discussed by the interdisciplinary team (IDT; group of health care professionals from various disciplines who collaborate to address the comprehensive needs of the resident), and the conclusion was made that R #1 had likely fallen. 4. The administrator revealed that looking at all the evidence the facility should have probably reported the incident to the SA as an injury of unknown origin.

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:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	325062	A. Building B. Wing	12/05/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Paloma Springs Healthcare LLC	1400 North Silver Street T OR C, NM 87901

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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 0637 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Assess the resident when there is a significant change in condition **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on record review and interview, the facility failed to complete a significant change (major decline or improvement in the patient's health status) MDS Set assessment within 14 days after the facility determined a significant change in the resident's physical or mental condition for 1 (R #1) of 3 (R #1, R #2, and R #3) residents reviewed for MDS. This deficient practice could likely result in the residents not receiving the appropriate care and services they need. The findings are:A. Record review of R #1's physician orders revealed an order dated 11/06/25 admit to hospice care (special kind of care that focuses on a person's quality of life and dignity near the end of life) effective 11/06/25. B. Record review of R #1's significant change of condition MDS assessment dated [DATE], revealed the MDS assessment was not signed off by the RN until 12/01/25. C. On 12/05/25 at 12:40 PM, during an interview with the MDS coordinator, she confirmed that the significant change MDS assessment for R #1 was not signed off within 14 days. The MDS Coordinator confirmed that the significant change MDS assessments should be signed by the RN within 14 days of the change of condition.

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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 0638 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Assure that each resident's assessment is updated at least once every 3 months. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on record review and interview, the facility failed to ensure that an MDS assessment was completed every three months for 1 (R #8) of 4 (R #8, R #9, R #10, and R #11) residents reviewed for MDS assessments, when they failed to complete quarterly MDS assessments timely (completed 14 days after the assessment reference date (ARD)). This deficient practice could result in resident's assessments being outdated and residents not receiving care and treatment that meets their current needs. The findings are: A. Record review of R #8's quarterly MDS assessment dated [DATE] revealed the following: 1. ARD date of 11/14/25. 2. Not signed by the RN for completion. B. On 12/05/25 at 9:49 AM, during an interview, the MDS Coordinator (MSC) confirmed that R #8's MDS assessment was not completed on time.